SAMPLE APPLICATION LETTER

Date

Executive Director
PROVIDER
address 1
town, MA zip

Dear ,

Enclosed is the Department of Developmental Services, Quality Enhancement Division Application for Certification which must be completed and returned to me on or before , 2021. Receipt of the application by this date will automatically extend your current License and Certification, which are due to expire , 2021, until a new survey has been conducted.

Also enclosed is a report listing the services that are included in the Licensure and Certification and the individuals served at each location. If this information is incomplete or inaccurate, please make the changes directly on the list. Instructions are included in this packet. The corrected list must be signed and included with your completed application.

It is important that you identify an Agency Liaison who will be the primary contact for coordinating all scheduling and information gathering within your agency for purposes of the survey process. This person should have a working knowledge of the individuals being surveyed and the types of services being provided. A team leader will be assigned to your agency and will contact the Agency Liaison to discuss the upcoming certification process.

If you have any questions, please feel free to contact me at (857) 208-4329. Thank you, in advance, for your cooperation.

Sincerely,

Doreet Goldhaber
Director of Licensure and Certification

CC: Regional Quality Enhancement Director

INSTRUCTIONS FOR THE INDIVIDUAL AND SERVICE LOCATION LIST
PROVIDER VERIFICATION

Please note that as of 7/1/2010, and 7/1/2016 activity codes have changed. New instructions, and the new activity codes and definitions are as follows.

Please review and correct the attached Individual and Service Location List (Provider Verification Forms) so that they accurately reflect service information and identify all of the individuals served at each location where services subject to licensure and certification are provided.

1) Draw an "X" through any location on the list that does not currently exist.

2) Site ID/ unique ID – This is the unique QE number for each location Do not change

3) Service (Program Code and Description) – Correct/verify the program code

currently being used in the DDS purchase of service system. The current program codes are as follows:

ServiceGroup/ Type/ Service	PROGRAM CODE
Employment and Day Supports	
Employment Support Services	
Grouped Supported Employment /Enclaves - State Operated	4181
Individual Supported Employment	3168
Individual Supported Employment - State Operated	4168
Grouped Supported Employment /Enclaves	3181
MCB Supported Employment	9168
Community Based Day Services	
Community-based Day	3163
State Ops Community Based Day Services	4163
MCB Community-Based Day	9163
Residential and Individual Home Supports	

Respite Services	
State-Operated Site-based Respite Services	4182
State Operated Site-based Respite Services	4759
Site-based Respite Services	3182
Site-based Respite Services	3759
Individual Home Supports	
Less Than 24 Hour Residential Supports - D	9798
Less Than 24 Hour Residential Supports - A	3798
Less Than 24 Hour Residential Supports - B	3703
Less Than 24 Hour Residential Supports - C	4798
Placement Services	
MCB Placement (also inc. Shared Living; Home Share)	9150
Placement (also inc. Shared Living; Home Share)	3150
Respite (Adult) in Caregiver's Home	3702
Residential Services	
State-Operated Residential Services	4157
Residential Supports	3153
MCB Residential	9153
ABI-MFP Residential Services	
ABI/MFP Residential Habilitation	3751
ABI-MFP Placement Services	
ABI/MFP Shared Living - 24 Hour Support	3752

4) Location Address – Correct/verify the address

For **Placement Services** correct/verify that the address given is the corporate address.

Please correct/verify/ add all addresses where individuals are served, in a caretaker home (Placement Services). There is one list of all placement services provided to individuals with intellectual disabilities.

The individual home addresses should be listed separately as sub-locations, noting where each individual is living.

For **Individual Home Supports** correct/verify that the address given is the corporate address. Please correct/verify/ add all addresses where individuals are served, either in their own home or a provider owned or leased home. There is one list of all Individual Home Support Services, noting the address of the administrative office responsible for oversight of this grouping of individuals with intellectual disabilities.

The individual home addresses should be listed as sub-locations, noting where each individual is living, and the number of hours of service by individual.

Individuals receiving less than 15 hours per week of Individual Support Services, or who live in a family home, will not be included in the survey process and are therefore not listed in this packet. If any of these individuals are listed in the packet, identify them by placing a "<15" or "Family Home" next to each of their names. People whose individual supports are primarily not direct support hours such as representative services or PCA case management, should also be identified so they will also be excluded from the survey.

For **Employment Supports, Community Based Day** locations

correct/verify that the address given is the address that serves as the support service location where services are directly provided and/ or as the administrative hub for this service (e.g. employment records and staff are housed here, while individual is actually employed in a community job). Please correct/verify/ add all addresses where individuals are served. The community job can be listed separately as sub-locations.

Many individuals are attending these services on a part-time basis; please note the number of hours of service for each individual

For **Residential Supports** locations, **Community Based Day** locations, and **Site-Based Respite/Emergency Residence** locations, each location should be listed separately.

5) QE Category – QE Category is a brief description of the service. Correct/verify the QE Category for the location. The following is a description of each QE Category:

- **Category A –** home providing 24 hour staffing supports; provider leases or owns the home.
- **Category B –** home providing 24 hour staffing supports; individual leases or owns the home.
- **Category C –** home providing less than 24 hour staffing supports; provider leases or owns the home.
- **Category D –** home providing less than 24 hour staffing supports; individual leases or owns the home.
- **Category E –** placement service;
- **Category F –** site-based respite/emergency residence.
- **Category G –** employment supports, community based day supports, comprehensive integrated employment services and group supported employment

6) Capacity – correct/verify the number of individuals who are served at the location.

For Placement Services, Tier 1 and Tier 2, and Individual Support Services, put the maximum number of individuals served by your agency for each of these services, and record the capacity at each sub-location.

7) Individual Information - Verify the individual information at each location including individuals not funded by DDS; e.g. private pay, out of state.

- If the individual information is correct and the individual is receiving services at the location, no changes are necessary
- If the individual no longer receives services at the location, write the date they left on the line provided Date Left Location

- If the individual was never served at the location, check the box next to the name

  Never at Location

- If individuals are missing from the list, add their names, social security number, the dates they started in the service, and the hours of service they are receiving on the additional lines provided.
- Identify whether interpreters are needed for individuals who are Deaf or Hard of Hearing.
- Note whether any individual is receiving less than 7 hours per week of supports.

8) Some of the service locations that are currently operational and need to be licensed by DDS may not have a location specific form in this packet. Blank forms at the end of the packet have been provided for your use in identifying these locations and the people served there. If your agency has a document that provides all the requested information for each of the locations not listed, it may be attached to the packet instead of transferring the information to the blank individual and service location forms.

9) Site based respite services will be reviewed when at least one individual is using the service. The QE Director or Team Leader will contact you prior to the survey dates to obtain the current schedule of when at least one individual will be using the service.

Thank you for your assistance in correcting and verifying this information

DEPARTMENT OF DEVELOPMENTAL SERVICES
OFFICE OF QUALITY ENHANCEMENT
APPLICATION FOR LICENSURE AND CERTIFICATION

Please complete or correct each section.

I. APPLICANT INFORMATION:

A. Applicant Name:

B. Federal Employer Identification Number (FEIN):

C. Office Address:

D. Executive Director:

E. Office Telephone:

F. Provider Liaison Name: Email Address:

G. DDS Regions where services are located: Central/West____ North____ South____ Greater Boston____

II. HAS THE APPLICANT EVER HAD A PROGRAM WHICH DDS OR ANY OTHER STATE AGENCY:

A. Refused to license or to renew licensure? Yes____ No____

B. Revoked? Yes____ No____

C. Suspended? Yes____ No____ Reinstated? Yes____ No____

D. Cancelled or terminated contracts for cause? Yes____ No____

If yes to any of the above, attach a separate page listing name and address of program, original date of the license, action taken by DDS or other agency, date, and reason.

III. OTHER ACCREDITATION:

A. Has applicant applied for a national accreditation? Yes____ No____

If no, go to Part IV. If yes, complete B - G.

B. Accrediting Organization: The Council____ CARF____ Other____

C. For what services has the applicant applied for accreditation? Please refer to services below, and check all that apply:

CARF NOMENCLATURE:		**DDS RES/IHS SERVICES:**
_____	Community Housing/ Supported Living	Residential
_____	Community Housing/ Supported Living	ABI/ MFP Residential
_____	Host family / Shared Living Services	Placement Services
_____	Host family / Shared Living Services	ABI/ MFP Placement Services
_____	Supported Living services	Individual Home Supports
_____		Planning and Quality Management

CARF NOMENCLATURE:		**DDS EMPLOYMENT/DAY SERVICES:**
_____	Community Integration	Community Based Day Services
_____	Community Employment services	Employment Supports
_____	Organizational Employment Services	
_____		Planning and Quality Management

D. Has the agency received accreditation? Yes____ No____

If yes, please enclose the Certificate or Letter of Accreditation and the most recent accreditation report. The CARF Crosswalk for DDS in Massachusetts must also be enclosed.

E. Date of Accreditation: _____ Type: _____ Expiration Date: _____

F. Corrective Plan? Yes___ No___ If yes, please attach.

G. Does the applicant intend to use the accreditation process in lieu of DDS's certification review? Yes___ No___

IV. LICENSURE AND CERTIFICATION REVIEW LIST:

A. For what services is the applicant applying for licensure and certification?

_____ Residential/ I H S Service Grouping (respite not certified)

_____ Residential Services (24/7)

_____ Residential Services for individuals with ABI / MFP waiver

_____ Placement Services (individuals serviced in a caretaker home)

_____ ABI-MFP Placement Services

_____ Individual Home Supports (15 hours per week or more of services)

_____ Planning and Quality Management

_____ Employment/ Day Supports Service Grouping

_____ Employment Supports (individual supported employment and enclaves)

_____ Community Based Day Services

_____ Planning and Quality Management

B. Please complete if eligible for targeted review. Type of Review interested in:

Res/IHS Service Group	_____ Full Review	_____Targeted Review
Employment/Day Supports Service Group	_____ Full Review	_____Targeted Review

V. INDIVIDUAL SERVICE LOCATION LISTS:

Please include locations serving individuals with intellectual disabilities only.

Attached is the QE Individual and Service Location List for your agency along with instructions for verifying and correcting the information. Once the verification is completed, please return it with the completed Application. Please also correct and update sub-location information.
Several types of services are tied to a corporate office, and each location where services are actually delivered is then listed as separate sub-locations. For example Placement Services are tied to a Provider address. This address is the location administratively responsible for the set of services. Each caretaker home where the services are being delivered should be listed as a sub-location

VI. LEGAL PROCEEDINGS:

Has the applicant or any of its employees been a party to any lawsuit or hearing or the subject of a criminal or civil investigation related to contracts or services which are funded by the Massachusetts Department of Developmental Services or other governmental agency? Yes ___ No ___

If yes, attach a separate page outlining the history, nature and disposition of the legal proceedings or investigation.

VII. AUTHORIZATION:

I certify, under the pains and penalties of perjury, that all the information contained herein is correct and complete. I will provide any information to the Department that may be required for certification.

Date of Authorization	Authorized Signature
	Type or Print Name
	Title

Individual and Service Location List

Provider Verification

QE Site ID: number **Service:** 3153 - Residential Supports

Location Name: address **QE Category:** A **Capacity:** 4

Date closed (Print If site is closed): _____

Individual's Name	Date Left Location	Never At Location	SSN
Total individual count:	**0**		

Individual's Name	Social Security Number	Date of Entry
Individual's Name	Social Security Number	Date of Entry
Individual's Name	Social Security Number	Date of Entry
Individual's Name	Social Security Number	Date of Entry
Individual's Name	Social Security Number	Date of Entry

QE Site ID:		**Service:**	3153 - Residential Supports
Location Name:		**QE Category:**	A **Capacity:**
Date closed (Print If site is closed):	_____		

Individual's Name	**Date Left Location**	**Never At Location**	**SSN**
Total individual count:	**0**		

Individual's Name	Social Security Number	Date of Entry
Individual's Name	Social Security Number	Date of Entry
Individual's Name	Social Security Number	Date of Entry
Individual's Name	Social Security Number	Date of Entry
Individual's Name	Social Security Number	Date of Entry

BLANK INDIVIDUAL AND SERVICE LOCATION LIST- Please complete for each new location

Individual and Service Location List

Provider Verification

Complete this form for Residential supports and Community Based Day Supports Services

- ☐ 4167 State Ops Community Based Day Services
- ☐ 4182 State-Operated Site-based Respite Services
- ☐ 4759 State Operated Site-based Respite Services
- ☐ 4157 State-Operated Residential Services
- ☐ 3153 Residential Supports
- ☐ 3182 Site-based Respite Services
- ☐ 3163 Community-based Day
- ☐ 4163 State Ops Community Based Day Services
- ☐ 9153 MCB Residential
- ☐ 3759 Site-based Respite Services
- ☐ 9163 MCB Community-Based Day
- ☐ 3751 ABI/MFP Residential Habilitation

QE Site ID: _____		**Service:** _____	
Location Name: _____		**QE Category:** ___	**Capacity:** ___

Individual's Name	Social Security Number	Date of Entry
Individual's Name	Social Security Number	Date of Entry
Individual's Name	Social Security Number	Date of Entry
Individual's Name	Social Security Number	Date of Entry
Individual's Name	Social Security Number	Date of Entry

BLANK INDIVIDUAL AND SERVICE LOCATION LIST- Please complete for each new location

Individual and Service Location List

Provider Verification

Complete this form for each Individual Home Support, Placement and Employment Services, listing each of the caretaker homes/ community businesses as sub-locations. Also complete this form for any service which is site-less and offered throughout the community in one or more sub-locations.

- ☐ 9798 Less Than 24 Hour Residential Supports - D
- ☐ 9150 MCB Placement (also inc. Shared Living; Home Share)
- ☐ 4181 Grouped Supported Employment /Enclaves - State Operated
- ☐ 3150 Placement (also inc. Shared Living; Home Share)
- ☐ 3168 Individual Supported Employment
- ☐ 4168 Individual Supported Employment - State Operated
- ☐ 3181 Grouped Supported Employment /Enclaves
- ☐ 3798 Less Than 24 Hour Residential Supports - A
- ☐ 3703 Less Than 24 Hour Residential Supports - B
- ☐ 3702 Respite (Adult) in Caregiver's Home
- ☐ 9168 MCB Supported Employment
- ☐ 4798 Less Than 24 Hour Residential Supports - C
- ☐ 3752 ABI/MFP Shared Living - 24 Hour Support

QE Site ID: _____ **Service:** _____

Location Name: _____ **QE Category:** ___ **Capacity:** ___

Sub-Location Name: _____ **Capacity:** ___

Individual's Name	Social Security Number	Date of Entry	Hrs of service
Individual's Name	Social Security Number	Date of Entry	Hrs of service
Individual's Name	Social Security Number	Date of Entry	Hrs of service