**University of Massachusetts Medical School**

**Disability & Community Services**

**Provider Network Administration Unit**

**ABI Waiver and MFP Waiver Provider Enrollment Checklist**

Should you have questions please contact the Provider Network Administration Unit at (855) 300-7058 or [ProviderNetwork@umassmed.edu](file:///C%3A%5CUsers%5CBurnsS1%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CLV057P7K%5CProviderNetwork%40umassmed.edu)

CHECKLIST - Before returning your application, refer to this list of items that you must include with your application materials. This list is to help ensure that your application is complete.

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| Applicant Name:       |

1. **APPLICANTS MUST SUBMIT:**

**[ ]** MassHealth Provider Application – HCBS Waiver

[ ]  Massachusetts Medicaid Program Provider Agreement

[ ]  MassHealth Trading Partner Agreement

[ ]  Data Collection Form

[ ]  Authorization for Electronic Funds Transfer (EFT) of MassHealth payments and either:

 [ ]  Voided Check; **OR**

[ ]  Bank Letter indicating: Legal name on account, type of account, routing number and account number

[ ]  Massachusetts Substitute W-9

[ ]  Provider Enrollment Checklist

[ ]  Federally Required Disclosures form

[ ]  A tax coupon, Notice of New Employer Identification Number Assigned, or other documentation from the Internal Revenue Service (IRS) verifying your tax identification number. The verification of your tax identification number must be a document from the IRS.

[ ]  Policy on screening employees, volunteers, or contractors for Criminal Offender Record Information

[ ]  Proof of Liability Insurance and Workers Compensation Insurance

[ ]  Job description of key personnel (Contract Manager, Program Director)

[ ]  Job description of each job title/service providing direct service to Participants

[ ]  Description of experience providing the service(s) for which you are applying as well as your experience working with individuals with disabilities and/or elders. This should include staff orientation, ongoing staff development activities, training and ongoing supervision to ensure all staff are appropriately trained and managed

[ ]  Additional requirements outlined in Service Specific Requirements Section IV

1. **GEOGRAPHICAL, LANGUAGE, AND POPULATION CAPCITY TO PROVIDE SERVICES:**
2. Please indicate the regions where you are willing to provider services:

(*See Appendix 1 for a list of municipalities by region/county)*

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| [ ]  | Boston/Metro | [ ]  | Central | [ ]  | Southeast/Cape/Islands | [ ]  | Northeast | [ ]  | Western |

1. Please indicate the counties where you are willing to provide services:

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| [ ]  | Barnstable | [ ]  | Berkshire | [ ]  | Bristol | [ ]  | Dukes |
| [ ]  | Essex | [ ]  | Franklin | [ ]  | Hampden | [ ]  | Hampshire |
| [ ]  | Middlesex | [ ]  | Nantucket | [ ]  | Norfolk | [ ]  | Plymouth |
| [ ]  | Suffolk | [ ]  | Worcester |

If applicable, please list the towns that you do **not** have capacity to provide services to within a particular geographic area:

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| List towns:       |

1. Language: In addition to English, please indicate any languages you or your organization’s service provider staff can communicate fluently, including American Sign Language (ASL):

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| Languages:       |

1. Population: Please select the population(s) which you have experience working with:

[ ]  Individuals with Acquired Brain Injury

[ ]  Elderly Individuals

[ ]  Individuals with Physical Disabilities

[ ]  Individuals with Intellectual Disabilities

[ ]  Individuals with Psychiatric Disabilities

[ ]  Substance Use Disorders

1. Current State Contract: Please indicate all state agencies you currently have contracts with:

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| [ ]  | Massachusetts Rehabilitation Commission (MRC) | [ ]  | Department of Developmental Services (DDS) |
| [ ]  | Department of Public Health (DPH) | [ ]  | Department of Mental Health (DMH) |
| [ ]  | Department of Children & Families (DCF) | [ ]  | MassHealth |
| [ ]  | Human Service Transportation (HST) Broker System | [ ]  | Other:       |
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1. **PROVIDER REQUIREMENTS**

Each participating provider is required to sign a MassHealth Provider Agreement by which it agrees to comply with the Federal and State laws, regulations, and policies governing the Waiver, including the standards for the specific Medicaid waiver service the provider will deliver.

Please review the following documents for provider requirements:

Regulations

* MassHealth All Provider Regulations (130 CMR 450):

[www.mass.gov/regulations/130-CMR-450-administrative-and-billing-regulations](http://www.mass.gov/regulations/130-CMR-450-administrative-and-billing-regulations)

* MassHealth Rates for Home and Community Based Waiver Regulations (101 CMR 359):

[www.mass.gov/regulations/101-CMR-35900-rates-for-home-and-community-based-services-waivers](http://www.mass.gov/regulations/101-CMR-35900-rates-for-home-and-community-based-services-waivers)

* MassHealth Home and Community Based Waiver Services (130 CMR 630):

[www.mass.gov/regulations/130-CMR-630000-home-and-community-based-services-waiver](http://www.mass.gov/regulations/130-CMR-630000-home-and-community-based-services-waiver)

Waiver Policies established by the Department of Developmental Services (DDS) and Massachusetts Rehabilitation Commission (MRC)

* Policy for ABI-RH and MFP-RS Waivers:

<https://www.mass.gov/files/documents/2017/12/26/policy-for-abi-rh-and-mfp-rs.pdf>

* Policy for ABI-N and MFP-CL Waivers:

* <https://www.mass.gov/files/documents/2017/12/26/abi-n-and-mfp-cl-policy.pdf>
* MRC Community Living Division Provider Manual:

<https://www.mass.gov/files/documents/2017/12/26/mrc-cl-practices-policies-procedures-2016.pdf>

1. **SERVICE – SPECIFIC REQUIREMENTS**

**INSTRUCTIONS:**Please submit all the related documentation for each service type which your organization is seeking to be qualified to provide. Organizations submitting an application for multiple service types will be credentialed for each type.

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| [ ]  | Adult Companion | [ ]  | Assisted Living |
| [ ]  | Chore Services | [ ]  | Community/Residential Family Training |
| [ ]  | Community Based Day Supports | [ ]  | Community Behavioral Health Support and Navigation |
| [ ]  | Day Services | [ ]  | Home Health Aide  |
| [ ]  | Homemaker  | [ ]  | Individual Support & Community Habilitation |
| [ ]  | Orientation & Mobility | [ ]  | Individual Living Supports  |
| [ ]  | Peer Support |
| [ ]  | Personal Care | [ ]  | Prevocational |
| [ ]  | Respite | [ ]  | Shared Home Supports |
| [ ]  | Skilled Nursing | [ ]  | Specialized Medical Equipment |
| [ ]  | Supportive Employment | [ ]  | Supportive Home Care Aide |
| [ ]  | Therapy Services (Occupational, Physical and Speech) | [ ]  | Transportation |

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| [ ]  **ADULT COMPANION (AC)**– ORGANIZATION AND INDIVIDUAL |

Non-medical care, supervision and socialization services provided to a Participant. Companions may assist or supervise the Participant with such light household tasks as meal preparation, laundry and shopping.

**REQUIREMENTS:**

* Health or Human Service organization or an individual with experience providing non-medical care, supervision, and socialization for adults with disabilities and/or elders.
* All organization staff or self-employed providers should meet the following qualifications:
	+ Be able to handle emergency situations; ***AND***
		- Have a high school diploma; ***OR***
		- Have life experience working with individuals with disabilities.

*Note: Per MassHealth regulations, spouses, guardians and parents of minor children cannot provide care to their family member/ward.*

**Documents to be submitted:**

[ ]  Resume of Program Director

**KEY STAFF CONTACT INFORMATION**

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| Name | Title | Email | Phone |
|       | Contract Manager |       |       |
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| [ ]  **ASSISTED LIVING (ALR)**- ORGANIZATION |

Services consist of personal care and supportive services (homemaker, chore, personal care services, meal preparation) that are furnished to Participants who reside in a qualified Assisted Living Residence (ALR) that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and provides supervision, safety and security. Services may also include social and recreational programs, and medication assistance (consistent with ALR certification and to the extent permitted under State law). Nursing and skilled therapy services are incidental rather than integral to the provision of Assisted Living Services. Intermittent skilled nursing services and therapy services may be provided to the extent allowed by applicable regulations.

**REQUIREMENTS:**

* Certified by the Executive Office of Elder Affairs (EOEA) in accordance with 651 CMR 12.00.

**Documents to be submitted:**

[ ]  Copy of EOEA Certification for Assisted Living for each site in which you are applying

[ ]  Attestation statement stating that your organization meets the applicable requirements of the [CMS Community Rule (42 CFR 441.301(c)(4)](https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider)) which indicates among other items the following:

* The ALR cannot be sited with a skilled nursing facility or on a campus with a nursing home, hospital or other long-term care facility;
* Each unit has lockable access and egress; AND
* Residents must have a legally enforceable residency agreement that provides protections comparable to those provided under landlord-tenant law.

[ ]  Description of experience providing ALR Services to adults (eighteen and over) with disabilities (intellectual disabilities, physical disabilities, acquired brain injuries, and psychiatric disabilities) including the organization’s ability to obtain clinical consultation to promote successful placement.

[ ]  Copy of the Residency Agreement/Lease used by the ALR

[ ]  Floor Plan (or drawing) of the Assisted Living Residence, available to waiver Participants, which identifies:

* Apartments with living, sleeping, bathing and cooking areas
* Limitations to waiver Participants of certain units within the building and indication of potential units either on the floor plan or in another attachment

[ ]  Resume of Assisted Living Residence Director

[ ]  Orientation and annual training curriculum for staff. Please include the training title, objectives for the training and the name/credentials of the staff providing the training.

[ ]  Policy or procedure for setting room and board requirements.

**KEY STAFF CONTACT INFORMATION**

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| Name | Title | Email | Phone |
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| [ ]  **CHORE SERVICES (CS)** – ORGANIZATION AND INDIVIDUAL |

An unusual or infrequent household maintenance task that is needed to maintain the Participant’s home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls; tacking down loose rugs and tiles; and moving heavy items of furniture in order to provide safe access and egress.

**REQUIREMENTS:**

* Must be a Health or Human Service organization or an individual with experience providing services needed to maintain the home in a clean, sanitary, and safe condition.

**Documents to be submitted:**

[ ]  Resume of Program Director

**KEY STAFF CONTACT INFORMATION**

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| Name | Title | Email | Phone |
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| [ ]  **COMMUNITY-BASED DAY SUPPORTS (CBDS)** – ORGANIZATION  |

Using a small group model, CBDS provides a flexible array of individualized supports through community activities that promote socialization, peer interaction and community integration. The service is designed to enable an individual to enrich his or her life and enjoy a full range of community participation by providing opportunities for developing, enhancing and maintaining competency in personal and social interactions through community membership and integration. The service may include career exploration, including assessment of interests through volunteer opportunities or situational assessments; meaningful opportunities in the community to enable fuller participation in community life; development and support activities of daily living and independent living skills; socialization opportunities; enhancement of interpersonal skills; and pursuit of personal goals, interests and hobbies. The service is intended for individuals of working age who may be on a pathway to employment, as supplemental services for individuals who are employed part-time and need a structured and supervised program of services during the time that they are not working, and for individuals who are of retirement age.

Note:

* CBDS is intended to be a community opportunity-focused alternative to site-based Day Services for ABI/MFP Waiver participants. While ABI/MFP Waiver participants may participate in both Day Services and CBDS as indicated in their waiver plan of care, Waiver participants may **not** receive **both** CBDS and Day Services **on the same day**.
* CBDS providers cannot bill for intake sessions but it is allowable for a case manager/service coordinator to authorize on the participants POC for the CBDS service to be trialed prior to long-term schedule being included. The trial must include the participants’ full participation in the planned activity.

**REQUIREMENTS:**

o    Organizations must demonstrate:

* Prior experience providing functional, community-based services and living skills training, and
* A commitment to the philosophy of maximizing independence, commitment to encouraging and supporting meaningful community membership, and an appropriate blend of comprehensive services.

o    CBDS supervisory staff must have a college degree plus experience in providing community-based services to individuals with disabilities or at least three years’ comparable work experience providing community-based services to individuals with disabilities.

* CBDS direct care staff must have at least one-year comparable work experience providing community-based services to individuals with disabilities (for example, experience in providing peer support or self-advocacy and/or skills training to support independence, family leadership, etc.).
* CBDS providers who are also providers of Residential Habilitation must identify a corporate address or alternate address and CBDS operational capacity that are not co-located with a residential program.
* CBDS providers who are also providers of Day Habilitation must demonstrate CBDS operational capacity that is physically and programmatically separate and distinct from a Day Habilitation setting and Day Habilitation services. Common spaces can be shared such as restrooms, conference rooms, kitchen etc.
* CBDS providers who are also providers of waiver Day Services must demonstrate CBDS operational capacity that is physically and programmatically separate and distinct from a Day Services setting and Day Services programming. Common spaces can be shared such as restrooms, conference rooms, kitchen etc.
* All provider owned/operated settings in which Waiver participants may gather must meet all requirements of 130 CMR 630.435 *Location Requirements for HCBS Waiver Providers* for locations in which HCBS waiver services are provided.

**Documents to be submitted:**

[ ]  A brief description of the organization’s experience delivering meaningful, community-based services for individuals through similar sited or non-sited programs that support community membership and individual choice.

[ ]  A detailed description of proposed programmatic elements, including the following:

* how the organization will assess the individual participants’ interests, needs and abilities to establish meaningful individualized goals. Specific areas to be addressed may include ability to self-administer medications, transfer safely in the community and how staffing ratios are determined,
* the planned staffing model, including the programs ability to assess self-administration ability, obtain clinical expertise (e.g. OT, PT, SLP, skilled nursing) to inform the programs ability to serve individuals safely,
* a typical day of service delivery,
* how activities will promote meaningful community integration,
* the program’s capacity to provide transportation (for example, passenger car, chair car with capacity for 4 chairs) to access community events,
* the program’s capacity, and
* how participant groupings for various community activities will be identified.

[ ]  Sample weekly program schedule

[ ]  If applicable, documentation indicating current licensure or certification requirements met by another EOHHS state agency, for example:

* Department of Developmental Services (DDS) licensure/certification requirements at 115 CMR 7.00 & 8.00 for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission
* Department of Mental Health (DMH) licensure requirements at 104 CMR 28.00, Subpart B, for Community Programs

[ ]  If applicable, for providers of Adult Intellectual Disability (ID) Waiver, CBDS services, a description of how the proposed ABI/MFP CBDS programming is different from the organization’s CBDS services for the ID waiver population.

[ ]  If applicable, for providers of ABI/MFP Day Services, a description of how the proposed CBDS programming is different from the organization’s site-based Day Services.

[ ]  Job description of each job title/service providing direct service to Participants

[ ]  Resume of Program Director

**KEY STAFF CONTACT INFORMATION *FOR ORGANIZATIONS ONLY***

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| Name | Title | Email | Phone |
|       | Contract Manager |       |       |
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| [ ]  **COMMUNITY BEHAVIORAL HEALTH SUPPORT AND NAVIGATION (CSN) -** ORGANIZATION  |

Community Behavioral Health Support and Navigation is an array of services delivered by community-based, mobile, paraprofessional staff supported by a clinical supervisor to participants with behavioral health needs whose psychiatric diagnosis or substance use disorder(s) interferes with their ability to access essential medical and behavioral health services. The services provided are tailored to the needs of the individual and are designed to ensure that the participant has access to, and in fact utilizes, needed behavioral health services. Community Behavioral Health Support and Navigation does not include clinical treatment services, but rather provides outreach and support services to enable participants to utilize clinical treatment services and other supports. Community Behavioral Health Support and Navigation assists the participant with attaining his/her goals in the plan of care and works to mitigate barriers to doing so.

**REQUIREMENTS:**

* Any not-for-profit or proprietary organization must provide mental health or substance use disorder services and be licensed within the Commonwealth of Massachusetts.
* Organizations providing Community Behavioral Health Support and Navigation must employ a multi-disciplinary staff with established experience, skills, and training in the acute treatment of mental health and co-occurring mental health and substance use conditions, including a minimum of one full time master’s or doctorate-level, licensed behavioral health clinician responsible for the operation of the program and supervision of staff. Supervision must include Participant-specific supervision, as well as a review of mental health, substance use disorder, and medical conditions, as well as integration principles and practices.
* Organizations must ensure that:
	+ A psychiatric clinician is available for psychiatric phone consultation within 15 minutes of request, and for a face-to-face evaluation within 60 minutes of request, when clinically indicated.
	+ Service is accessible to participants seven days per week. *An* *answering machine or answering service directing callers to call 911 or the ESP/MCI or go to a hospital emergency department does NOT meet this requirement*.
* Organizations must ensure that staff providing Community Behavioral Health Support and Navigation are mobile, community-based staff that have a minimum of a Bachelor’s degree in a Human Services field or 3 years comparable community based behavioral health experience and experience working in community settings with individuals with disabilities who have behavioral health needs.
* The provider ensures that staff receive documented, annual training to enhance and broaden their skills. The training topics include but are not limited to:
	+ Common diagnosis across medical and behavioral health care
	+ Engagement and outreach skills and strategies
	+ Service coordination skills and strategies
	+ Behavioral health and medical services, community resources and natural supports
	+ Principles of recovery and wellness
	+ Cultural competence
	+ Managing professional relationships with Members, including but not limited to boundaries, confidentiality, and peers as CSP workers
	+ Service termination.

**Please indicate if your organization is approved to provide one or more of the following. Please select all that apply:**

 [ ]  Community Based Flexible Supports (CBFS) through the DMH

[ ]  Community Support Program (CSP) through MassHealth or a MassHealth-contracted Managed Care Organization (MCO), Accountable Care Organization (ACO) or Integrated Care Organization (OneCare)

 [ ]  Program of Assertive Community Treatment (PACT) through DMH

 [ ]  Behavioral Health Community Partner (BHCP) through MassHealth

**If you selected one or more of the above services, please submit the following documents:**

[ ]  Description of experience providing Community Behavioral Health Support and Navigation or a similar service with a description of the organization’s practice of staff supervision.

[ ]  Credentials of behavioral health clinician(s) responsible for overseeing the organization’s delivery of waiver CSN services.

[ ]  Documentation indicating qualification as provider of one or more of the following:

* Community Based Flexible Supports (CBFS) through the DMH
* Community Support Program (CSP) through MassHealth or a MassHealth-contracted Managed Care Organization (MCO), Accountable Care Organization (ACO) or Integrated Care Organization (OneCare)
* Program of Assertive Community Treatment (PACT) through DMH
* Behavioral Health Community Partners (BHCP) through MassHealth

[ ]  Organizational Chart for the service(s) including supervision and contract management oversight

[ ]  Job description for each job title/service providing direct service to Participants

[ ]  Resume of Program Director

**If your organization is not currently an approved provider for CBFS, CSP, PACT or BHCP, please submit the following documents:**

[ ]  Description of experience providing Community Behavioral Health Support and Navigation or a similar service with a description of the organization’s practice of staff supervision, including:

* How your organization will ensure that the CSN service is available to Participants seven days per week, directly, or on an on-call basis, where a psychiatric clinician is available for phone consultation within 15 minutes when clinically appropriate.
* A detailed staffing plan and an organizational chart that includes supervision and contract management oversight.
* The organization’s proposed service planning structure including a description of how the CSN service staff will collaborate with the Participant in conducting a needs assessment and completing a comprehensive, individualized CSN service plan that has measurable goals and outlines all activities to be performed and/or coordinated by the provider, and that is updated at least quarterly or more frequently if there are significant changes to the participant’s needs.
* Description of your staff development/training infrastructure and annual course offerings.

[ ]  Credentials of behavioral health clinician(s) responsible for overseeing the organization’s delivery of waiver CSN services.

[ ]  Resume of Program Director

**KEY STAFF CONTACT INFORMATION**

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| Name | Title | Email | Phone |
|       | Contract Manager |       |       |
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| [ ]  **COMMUNITY/RESIDENTIAL FAMILY TRAINING (CRFT)** – ORGANIZATION AND INDIVIDUAL |

A service designed to provide training and instruction about the treatment regimes, behavior plans, and the use of specialized equipment that support a Participant in the community. Community/Residential Family Training may also include training in family leadership, support of self-advocacy and independence for the family member. The service enhances the skills of the family to assist the waiver Participant to function in the community and at home.

**REQUIREMENTS:**

* Must be a Health or Human Service organization or an individual who is engaged in the business of providing Family Training or similar service
* Family Training staff must have relevant state and federal licensure or certification requirements in their discipline (if applicable)
* Staff must have experience in providing peer support, self-advocacy, and skills training, independence and family leadership

**Documents to be submitted:**

[ ]  Resume of Program Director

[ ]  Professional license of Program Director (if applicable):

**KEY STAFF CONTACT INFORMATION**

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| Name | Title | Email | Phone |
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| [ ]  **DAY SERVICES (DS)** - ORGANIZATION |

A structured, site-based, group program for Participants that offers assistance with the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, that takes place in a nonresidential setting separate from the Participant’s private residence or other residential living arrangement. Services often include assistance with learning activities of daily living and functional skills; language and communication training; compensatory, cognitive and other strategies; interpersonal skills, prevocational skills; and recreational and socialization skills.

**REQUIREMENTS:**

* Must be a Health or Human Service organization must be engaged in the business of providing Day Services to persons with disabilities and/or elders.
* Must meet the MassHealth HCBS Waiver Regulations regarding Location Requirements (130 CMR 630.435).
* Must have experience providing functional, community-based services and living skills training.
* Programs must employ a designated Program Director who must have a Master’s degree in health and human services related field or a Bachelor’s degree with five years of experience working with adults with disabilities and/or elders.
* Senior staff must have a Bachelors in rehabilitation or related field, and two years of experience working with adults with disabilities and/or elders.
* Other staff must have a high school diploma and two years of experience working with adults with disabilities and/or elders.
* Fire drills must be conducted at least quarterly during business hours.
* Must have the ability to access relevant clinical support as needed.
* Must have an organizational structure to support the delivery and supervision of day services (i.e. OT, PT, ST, Behavioral, etc.), including ability to plan and deliver services in the prescribed settings
* At a minimum, must operate the service between the hours of 9 a.m. and 4 p.m., Monday through Friday.
* At a minimum, must maintain a direct care staff-to-Participant ratio between 1:4 and 1:6.
* Must submit service documentation as described in the MRC Provider Standards.

**Documents to be submitted by existing Day Service providers, who are either MassHealth enrolled or State Agency certified/licensed:**

[ ]  Description of experience providing Day Services or similar services to individuals with disabilities and/or elders that demonstrates your organization’s:

* Understanding of the philosophy of independent living, participant participation and community integration
* Experience incorporating peer support, prevocational and skills training
* Ability to seek out and integrate necessary clinical expertise such as neuropsychology, occupational, physical and speech therapies
* Plan for medication administration
* Person-centered planning process inclusive of assessment and goal setting process

[ ]  Documentation indicating current Day Service Provider approval for **each** site that you are applying for:

* Documentation that indicates the organization has met the requirements of 130 CMR 404.000 Adult Day Health Services; ***OR***
* 130 CMR 419.000 as a Day Habilitation Program Services; ***OR***
* EOHHS agency for day services licensure/certification standards for 115 CMR 7.00 Standards for All Services and Supports: DDS (115 CMR 7.00) or DMH 104 CMR 28.00 Licensing and Operational Standards for Community Programs: Subpart B

[ ]  Resume of Program Director

[ ]  Occupancy Permit which includes capacity and current census

**Documents to be submitted by new Day Service providers:**

[ ]  Description of experience providing Day Services or similar services to individuals with disabilities and/or elders that demonstrates your organization’s:

* Understanding of the philosophy of independent living, participant participation and community integration
* Experience incorporating peer support, prevocational and skills training
* Ability to seek out and integrate necessary clinical expertise such as neuropsychology, occupational, physical and speech therapies
* Plan for medication administration
* Person-centered planning process inclusive of assessment and goal setting process

[ ]  Day Program organization chart

[ ]  Resume of Program Director and applicable professional license type(s) and number(s)

[ ]  Occupancy permit which includes capacity and site address

[ ]  Local fire department inspection report

[ ]  Current local Board of Health inspection or certificate (e.g. Food Establishment permit). If the town or city where the program will be sited does not require a Board of Health inspection, the provider must submit supporting documentation

[ ]  A floor plan (or drawing) of the proposed program site which:

* Labels all rooms for use, with specifics as to length and width of each space
* Provides square footage for each room or space
* Clearly labels closet, storage areas, hallways, lobbies and similar spaces with the dimensions indicated

[ ]  Copy of the evacuation plan for meeting the special needs of members, under circumstances requiring emergency evacuation

**KEY STAFF CONTACT INFORMATION**

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| Name | Title | Email | Phone |
|       | Contract Manager |       |       |
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| [ ]  **HOME HEALTH AIDE (HHA)** - ORGANIZATION |

A person who performs personal care services, such as simple dressing changes that do not require the skills of a registered or licensed nurse, assistance with medications that are ordinarily self-administered and that do not require the skills of a registered or license nurse, assistance with activities that are directly supportive of skilled therapy services and routine care of prosthetic and orthotic devices.

**REQUIREMENTS:**

* Any not-for-profit or proprietary organization must have experience providing homecare services.
* Individuals employed by the agency must have CPR/First Aid and either a:
	+ Certificate of Home Health Aide Training; ***OR***
	+ Certificate of Certified Nurse’s Aide Training; ***OR***
	+ Registered Nurse (RNs) and Licensed Practical Nurse (LPNs) valid Massachusetts Nursing license.
* All agencies must contact the Nurse’s Aide Registry prior to hiring an individual who will provide direct care to Participants or have access to Participants or their property to ascertain if there is any sanction, finding or adjudicated finding of patient or resident abuse, neglect, mistreatment or misappropriation of patient or resident property against the prospective employee.
* Supervision must be available during regular business hours, and on weekends, holidays, and evenings for staff providing services to participants during these times.
* Supervision of Home Health Aides must be provided by a Registered Nurse with a valid Massachusetts license and must be carried out at least once every three months.
* In-home supervision must be done with a representative sample of Waiver Participants.

**Documents to be submitted:**

[ ]  Resumes and professional license number for the staff providing supervision to HHA

[ ]  A copy of your organization’s Automated Voice Response System (AVRS) access letter for the Nurse’s Aide Registry

*Note: Per MassHealth regulations, spouses, guardians and parents of minor children cannot provide care to their family member/ward.*

**KEY STAFF CONTACT INFORMATION**

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| [ ]  **HOMEMAKER (HM)** – ORGANIZATION AND INDIVIDUAL |

A person who performs light housekeeping duties (for example, cooking, cleaning, laundry, and shopping) for the purpose of maintaining a household

**REQUIREMENTS:**

* Any not-for-profit or proprietary organization or self-employed provider must be engaged in the business of providing Homemaker services.
* Staff providing these services must have at least one of the following qualifications:
	+ Certificate of 40-hour homemaker training; ***OR***
	+ Certificate of 60-hour personal care training; ***OR***
	+ Certificate of home health aide training; ***OR***
	+ Registered Nurse (RNs) and Licensed Practical Nurse (LPNs) valid Massachusetts Nursing license
* All agencies must contact the Nurse’s Aide Registry prior to hiring an individual who will provide direct care to Participants or have access to Participants or their property to ascertain if there is any sanction, finding or adjudicated finding of patient or resident abuse, neglect, mistreatment or misappropriation of patient or resident property against the prospective employee.
* Providers must ensure that supervision is provided by Social Workers, Registered Nurses, and/or professionals with relevant expertise, with availability offered during regular business hours and on weekends, holidays and evenings.
* Supervision must be carried out at least once every three months by a qualified supervisor
* Supervision must be available during regular business hours, and on weekends, holidays, and evenings for staff providing services to participants during these times.
* In-home supervision must be done with a representative sample of Waiver Participants.

**Documents to be submitted:**

[ ]  Resumes of staff providing supervision

[ ]  A copy of your organization’s Automated Voice Response System (AVRS) access letter for the Nurse’s Aide Registry

*Note: Per MassHealth regulations, spouses, guardians and parents of minor children cannot provide care to their family member/ward.*

**KEY STAFF CONTACT INFORMATION**

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| [ ]  **INDEPENDENT LIVING SUPPORTS (ILS) -**  ORGANIZATION  |

Independent Living Supports ensures 24-hour seven days a week access to supportive services for persons who have intermittent, scheduled and unscheduled needs for various forms of assistance, but who do not require 24-hour supervision. It provides Participants with services and supports in a variety of activities such as: activities of daily living (ADLs) and instrumental activities of daily living (IADLs), support and companionship, emotional support, and socialization. The service is available to participants who choose to reside in locations where a critical mass of individuals reside who require such support and where providers of such supports are available.

Independent Living Supports are intended to be provided in a multi-tenant building, including but not limited to such settings as elderly/disabled public housing. The concept is that a building in which staff can be based (thus site-based), would have multiple regular waiver Participants and other clients in need of home-based care to whom they provide services in the building, and would have staff who could be available at non-scheduled times to respond to Participants who need support for issues that arise unexpectedly or are otherwise unplanned.

The service provider may not own the building in which the service is to be provided.

**REQUIREMENTS**

Any Health and Human Service organization may apply

* Providers applying must have an agreement with the owner of the building to provide this service to interested tenants of the building and have identified space within the building for staff.
* Providers must be in the business of providing services to persons with disabilities or persons over 65 years of age
* All agencies must contact the Nurse's Aide Registry prior to hiring an individual who will provide direct care to Participants or have access to Participants or their property to ascertain if there is any sanction, finding or adjudicated finding of patient or resident abuse, neglect mistreatment or misappropriation of patient or resident property against the prospective employee
* Must be able to initiate services with little or no delay in the designated site

**Documents to be submitted:**

[ ]  Written service narrative (5-page double-spaced limit) to include the following:

* + Description of experience providing Independent Living Supports and/or similar services including Homemaker, Personal Care, Adult Companion and Shared Home supports to individuals with disabilities and/or elders
	+ Description of the proposed Independent Living Supports site and how your organization is affiliated with the site
	+ Service capacity i.e. number of residents who can be served at one time
	+ Verification of on-site staff office including a description of the space and an attached agreement with the owner
	+ Detailed staffing pattern (including hours/schedule)
	+ Description of the organizations proposal to ensure that staff will be available 24/7 to meet scheduled and unscheduled resident needs
	+ Description of availability of clinical support and ongoing supervision of direct care staff

[ ]  Resume of Site Director

[ ]  Copy of the written agreement with the building owner of the proposed site demonstrating authorization to provide the service to interested residents and confirmation that there is an on-site staff office

[ ]  Orientation and annual training curriculum for staff. Please include the training title, objectives for the training and the name/credentials of the staff providing the training.

[ ]  Policy or procedure for setting room and board requirements.

[ ]  Copy of the Residency Agreement/Lease used by the organization.

**INDEPENDENT LIVING SUPPORTS KEY STAFF CONTACT INFORMATION**

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| [ ]  **INDIVIDUAL SUPPORT AND COMMUNITY HABILITATION (ISCH)**– ORGANIZATION AND INDIVIDUAL |

Regular or intermittent services designed to develop, maintain, and/or maximize the Participant’s independent functioning in self-care, physical and emotional growth, socialization, communication, and vocational skills, to achieve objectives of improved health and welfare and to support the ability of the Participant to establish and maintain a residence and live in the community.

**REQUIREMENTS:**

* Any not-for-profit or proprietary organization or self-employed provider must be engaged in the business of providing Individual Support and Community Habilitation or a similar service.
* All organization staff or self-employed providers should meet the following qualifications:
	+ Have a college degree (preferably in a human service field) OR
	+ At least 2 years comparable, community-based, life or work experience providing services to individuals with disabilities.

**Documents to be submitted by Organizations NOT licensed/certified by the Department of Developmental Services:**

[ ]  Resume of Program Director and applicable license type(s) and number(s)

[ ]  (2) Letters from Business references outlining providing a service similar to ISCH, clearly demonstrating community-based work experience providing skills training services to individuals with disabilities

**KEY STAFF CONTACT INFORMATION**

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| [ ]  **ORIENTATION & MOBILITY SERVICES (O&M)** – ORGANIZATION AND INDIVIDUAL |

Orientation and Mobility services teach an individual with vision impairment or legal blindness how to move or travel safely and independently in his/her home and community and include (a) O&M assessment; (b) training and education provided to Participants; (c) environmental evaluations; (d) caregiver/direct care staff training on sensitivity to blindness/low vision; and (e) information and resources on community living for persons with vision impairment or legal blindness. O&M Services are tailored to the individual’s need and may extend beyond residential settings to other community settings as well as public transportation systems.

**REQUIREMENTS:**

* Any not-for-profit or proprietary organization must respond satisfactorily to the Waiver provider enrollment process.
* All organization staff or self-employed providers should meet the following qualifications:
	+ Master’s Degree in special education with a specialty in orientation and mobility; ***OR***
	+ Bachelor’s Degree with a certification in orientation and mobility from an Academy for Certification & Education Professionals (ACVREP) certified university program
	+ Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional evaluation of the individual in the individual’s customary environment

**Documents to be submitted:**

[ ]  Resume of Program Director

[ ]  Description of experience providing Orientation and Mobility Services

**KEY STAFF CONTACT INFORMATION**

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| [ ]  **PEER SUPPORT** – ORGANIZATION AND INDIVIDUAL |

Services and supports designed to assist Participants to acquire, maintain or improve the skills necessary to live in a community setting. This service provides supports necessary for the Participant to develop the skills that enables them to become more independent, integrated into, and productive in their communities. The services enable the Participant to retain or improve skills related to personal finance, health, shopping, use of community resources, community safety, and other adaptive skills needed to live in the community.

**REQUIREMENTS:**

* Must be a Health or Human Service organization or an individual must be engaged in the business of providing Peer Support services or similar service.
* Peer Support staff must have relevant state and federal licensure or certification requirements in their discipline.
* Staff must have experience in providing peer support, self-advocacy, and skills training, independence and family leadership.

**Documents to be submitted:**

[ ]  Resume of Program Director and applicable professional license type

**KEY STAFF CONTACT INFORMATION**

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| [ ]  **PERSONAL CARE (PC)** – ORGANIZATION AND INDIVIDUAL  |

A range of assistance that is appropriate and necessary for the Participant’s health and well-being to enable the Participant to accomplish fundamental activities of daily living including, but not limited to, eating, toileting, dressing, bathing, transferring, and ambulation.

**REQUIREMENTS:**

* Must be a Health or Human Service organization engaged in the business of providing personal care services that employs personal care staff with a certificate in CPR/First Aid and at least one of the following qualifications:
	+ Certificate of 60-hour personal care training; ***OR***
	+ Certificate of home health aide training; ***OR***
	+ Certificate of nurse’s aide training; ***OR***
	+ Registered Nurse (RNs) and Licensed Practical Nurse (LPNs) valid Massachusetts license.
* All new employees exempt from any of the training components must receive the 3-hour orientation described in the Mass Council Training Outline.
* Agencies must contact the Nurse’s Aide Registry prior to hiring an individual who will provide direct care to Participants or have access to Participants or their property to ascertain if there is any sanction, finding or adjudicated finding of patient or resident abuse, neglect, mistreatment or misappropriation of patient or resident property against the prospective employee.
* Providers must ensure that supervision is provided by Social Workers, Registered Nurses and/or professionals with relevant expertise with availability offered during regular business hours and on weekends, holidays and evenings.
* Supervision must be available during regular business hours and on weekends, holidays, and evenings for staff providing services to participants during these times.
* PC Introductory Visits: Organizations must arrange for a RN/LPN to provide orientation to the personal care staff in the Participant’s home on the first day of service delivery to demonstrate the personal care tasks. LPNs may carry out the orientation visits if the LPN has a valid license in Massachusetts and is working under the direction of a RN.
* PC Supervision: A RN must provide in-home supervision of PC staff at least once every 3 months with a representative sample of waiver Participants. A written performance of the PC skills must be completed after each home visit. LPNs may provide in-home supervision if the LPN has a valid license in Massachusetts and works under the direction of a RN who is engaged in field supervision for a minimum of 20-hours per week and is responsible for the field supervision carried out by the LPN.
* Must have appropriate training facilities for providing Personal Care training and equipment with a minimum standard of equipment that includes: a bed with side rails, linen and blanket, running water and basins, towels and washcloths, chair, commode, wheelchair and walker. A variety of teaching methodologies such as lectures, equipment demonstrations, visual aids, videos, and handouts may be used.

**Documents to be submitted:**

[ ]  Resume of Program Director and copy of professional licensure

[ ]  A copy of your organization’s Automated Voice Response System (AVRS) access letter for the Nurse’s Aide Registry

*Note: Per MassHealth regulations, spouses, guardians and parents of minor children cannot provide care to their family member/ward.*

**KEY STAFF CONTACT INFORMATION**

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| [ ]  **PREVOCATIONAL (PV)**- ORGANIZATION |

A service that consists of a range of learning and experimental type of activities that prepares a Participant for paid or unpaid employment in an integrated, community setting. Services are not job-task oriented but instead are aimed at a generalized result (e.g. attention span, motor skills). The service may include teaching concepts such as attendance, task completion, problem solving and safety, as well as social skills training, improving attention span, and developing or improving motor skills. Basic skill-building activities are expected to specifically involve strategies to enhance the Participant’s employability in integrated, community settings.

**REQUIREMENTS:**

* Must be a Health and Human Service organization must be engaged in the business of providing prevocational services with experience in providing services that prepare a Participant for paid or unpaid employment in an integrated, community setting.
* Provider staff must have a college degree plus experience in providing community-based services to individuals with disabilities, or at least two years of comparable community-based, life or work experience providing services to individuals with disabilities.

**Documents to be submitted:**

[ ]  One-page description of your organization’s experience providing prevocational services that demonstrates how the organization supports the participant’s integration into the work environment

[ ]  Copy of DDS license/certification in accordance with 115 CMR 7.00

**KEY STAFF CONTACT INFORMATION**

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| [ ]  **RESPITE** - ORGANIZATION |

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

**REQUIREMENTS:**

* Agencies applying to be Respite providers must be:
	+ Licensed as a hospital by Massachusetts Department of Public Health (DPH) under 105 CMR 130.000; ***OR***
	+ Be certified as an assisted living residence by the Executive Office of Elder Affairs under 651 CMR 12.00; ***OR***
	+ Be licensed as a nursing facility by the DPH under 105 CMR 153.000; ***OR***
	+ Be licensed as a rest home by the DPH under 105 CMR 153.000; ***OR***
	+ Meet site based requirements established by the Department of Developmental Services under 115 CMR 7.00; ***OR***
	+ Be enrolled as a participating adult foster care provider in the MassHealth Program under 130 CMR 408.000.

**Documents to be submitted:**

[ ]  Description of the proposed Respite site(s) or model including address and capacity (if applicable)

[ ]  Copy of appropriate license or certificate indicating respite provider type

[ ]  Fee-schedule

**KEY STAFF CONTACT INFORMATION**

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| [ ]  **SHARED HOME SUPPORTS (SHS)**– ORGANIZATION (*To apply for this service the organization must be contracted as a Shared Living provider through DDS)* |

Shared Home Supports is an option that matches a Participant with a Shared Home Supports caregiver. This arrangement is overseen by a Residential Support Agency. The match between Participant and caregiver is the keystone to the success of this model. Shared Home Supports includes supportive services that assist with the acquisition, retention, or improvement of skills related to living in the community. This includes such supports as: adaptive skill development, assistance with activities of daily living (ADLs) and instrument activities of daily living (IADLs), adult educational supports, and social and leisure skill development. Shared Home Supports integrates the Participant into the usual activities of the caregiver’s family life. In addition, there will be opportunities for learning, developing and maintaining skills which may include the areas of ADLs, IADLs, social and recreation activities and personal enrichment. The Residential Support Agency provides regular and ongoing oversight and supervision of the caregiver.

The caregiver lives with the Participant at the residence of the caregiver or of the Participant. Shared Home Supports provides daily structure, skills training and supervision, but does not include 24-hour care. Shared Home Supports agencies recruit caregivers, assess their abilities, coordinate placement of and oversight for caregivers, and provide oversight of Participant living situations. The caregiver may not be a legally responsible family member.

Duplicative waiver and state plan services are not available to Participants receiving Shared Home Supports services. Share Home Supports services are not available to individuals who live with their immediate family unless the family member is not legally responsible for the individual and is employed as the caregiver, or the immediate family member (grandparent, parent, sibling or spouse) is also eligible for the Shared Home Supports and had received prior authorization, as applicable. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

Shared Home Supports may be provided to no more than two Participants in a home.

*Note: Per MassHealth regulations, spouses, guardians and parents of minor children cannot provide care to their family member/ward.*

**KEY STAFF CONTACT INFORMATION**

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| [ ]  **SKILLED NURSING (SN)** - ORGANIZATION |

The assessment, planning, provision, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of a school of nursing approved by a board of registration in nursing. Such services include only those services that require the skills of a nurse. Skilled Nursing services are provided by a person licensed as a registered nurse or a licensed practical nurse by a state’s board of registration in nursing.

**REQUIREMENTS:**

* Organizations applying to become a Skilled Nursing provider must be either a:
	+ Homemaker/Personal Care Agency; ***OR***
	+ Home Health Agency
* Skilled nursing services must be performed by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts Nursing license
* Agencies that provide Skilled Nursing services under the waiver do not need to meet the requirements for participation in Medicare, as provided in 42 CFR § 489.28

**Documents to be submitted:**

[ ]  Resume of Program Director

[ ]  Copy of professional licensure of Program Director

**KEY STAFF CONTACT INFORMATION**

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| [ ]  **SPECIALIZED MEDICAL EQUIPMENT (SME)** – ORGANIZATION AND INDIVIDUAL |

Devices, controls, or appliances to increase abilities in activities of daily living, or to control or communicate with the environment.

**REQUIREMENTS:**

* A provider must be an individual or entity engaged in the business of furnishing durable medical equipment, medical/surgical supplies, or customized equipment, or a provider participating in MassHealth under 130 CMR 409.000 or a pharmacy participating in MassHealth under 130 CMR 406.000.
* Medical Equipment Suppliers and pharmacies must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.
* Assistive Technology provider staff **and** individual providers must have either a:
	+ Bachelor’s degree in a related technological field and at least one year of demonstrated experience providing adaptive technological assessment or training; ***OR***
	+ Bachelor’s degree in a related health or human services field with at least two years of demonstrated experience providing adaptive technological assessment or training; ***OR***
	+ Three years of demonstrated experience providing adaptive technological assessment or training.
	+ Knowledge and experience in the following:
	+ Evaluation of the needs of an individual with a disability, including functional evaluation of the individual in the individual’s customary environment.
	+ Purchasing of, or otherwise providing for, the acquisition of assistive technology devices by individuals with disabilities.
	+ Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technological devices.
	+ Coordinating and using other therapies, interventions, or services with assistive technology devices.
	+ Providing technical assistance for an individual with disabilities, or when appropriate, the family of an individual with disabilities or others providing support to the individual.
	+ Providing technical assistance for professionals with other individuals whom provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.

**Documents to be submitted:**

[ ]  DME providers must have documentation that they meet requirements set forth in 130 CMR 409.000; ***OR***

[ ]  Copy of Massachusetts Board of Registration in Pharmacy license (Pharmacy Only)

[ ]  If not a DME provider or a pharmacy, a list of contracted manufacturers used for purchased products

[ ]  Copy of current accreditation letters

[ ]  For PERS providers only, a copy of documentation demonstrating compliance with UL Standards 1637 in accordance with 130 CMR 409.429(C)

[ ]  Fee Schedule

**KEY STAFF CONTACT INFORMATION**

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| [ ]  **SUPPORTED EMPLOYMENT (SE)**– ORGANIZATION  |

Regularly scheduled services that enable Participants, through training and support, to work in integrated work settings in which individuals are working toward compensated work, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals.

**REQUIREMENTS:**

* Any not-for-profit or proprietary organization must have a demonstrated experience and ability to successfully provide four components of supported employment programs, including Assessment, Placement, Initial Employment Supports and Extended Employment Supports.
* Must employ staff that has a bachelor’s degree preferably in a human service related field or at least 2 years of experience providing services to individuals with disabilities.

**Documents to be submitted:**

[ ]  One-page description of your organization’s experience providing supported employment that demonstrates how the organization supports the participant’s integration into the work environment

[ ]  Resume of Program Director

**KEY STAFF CONTACT INFORMATION**

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| [ ]  **SUPPORTIVE HOME CARE AIDE** - ORGANIZATION |

Supportive Home Care Aides perform personal care and/or homemaking services in accordance with waiver definitions, in addition to providing emotional support, socialization, and escort services to Participants with Alzheimer’s Disease/Dementia or behavioral health needs.

**REQUIREMENTS:**

* Any not-for-profit or proprietary organization must have experience providing homecare services
* Supervision of Home Health Aides must be provided by a Registered Nurse with a valid Massachusetts Nursing license
* Individuals employed by the agency must have a certificate in CPR and either a:
	+ Certificate of Home Health Aide Training; ***OR***
	+ Certificate of Certified Nurse’s Aide Training
* Individual Supportive Home Care Aides must have completed at least one of the following:
	+ An additional 12 hours of training in the area of servicing Participants with behavioral health needs; ***OR***
	+ The 12-hour training developed by the Alzheimer’s Association, Massachusetts Chapter on servicing Participants with Alzheimer’s Disease or related disorders
* All agencies must contact the Nurse’s Aide Registry prior to hiring an individual who will provide direct care to Participants or have access to Participants or their property to ascertain if there is any sanction, finding or adjudicated finding of patient or resident abuse, neglect, mistreatment or misappropriation of patient or resident property against the perspective employee.
	+ Supervision of Home Health Aides must be provided by a Registered Nurse with a valid Massachusetts license and must be carried out at least once every three months
	+ Supervision must be available during business hours and on weekends, holidays, and evenings for staff providing services to participants during these times
	+ In-home supervision must be done with a representative sample of MFP Participants.

*Note: Per MassHealth regulations, spouses, guardians and parents of minor children cannot provide care to their family member/ward.*

**Documents to be submitted:**

[ ]  Description of experience providing services to individuals with Alzheimer’s Disease/Dementia or behavioral health needs

[ ]  Direct care staff training requirement. Please submit one of the following:

* Attestation statement stating that your organization follows the 12-hour training on the Alzheimer’s Association Massachusetts Chapter; ***OR***
* Behavioral Health Training outline including a description of the course curriculum and duration of training

[ ]  Resumes and professional licensure number for the staff providing supervision to Supportive Home Care Aides

[ ]  A copy of your organization’s Automated Voice Response System (AVRS) access letter for the Nurse’s Aide Registry

**KEY STAFF CONTACT INFORMATION**

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|       | Referral |       |       |
|       | Emergency On-Call |       |       |

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| [ ]  **THERAPY SERVICES (OCCUPATIONAL, PHYSICAL AND SPEECH THERAPY)** – ORGANIZATION AND INDIVIDUAL |

Therapy services, including diagnostic evaluation and therapeutic intervention, designated to improve, develop, correct, rehabilitate, or prevent the worsening of physical or speech/language communication and swallowing disorders functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies or injuries.

**REQUIREMENTS:**

* Organization must be enrolled with MassHealth as either a Homecare Agency, Group Practice, Rehabilitation Center or chronic disease and rehabilitation inpatient hospital or outpatient hospital with authorized services to provide therapies.
* Individuals licensed in Massachusetts to provide Occupational, Physical or Speech Therapy
* Occupational Therapy
	+ An individual Occupation Therapist under MassHealth 130 CMR 432.404(B); ***OR***
	+ A home health agency participating under 130 CMR 403.000; ***OR***
	+ A group practice under MassHealth 130 CMR 432.404 (B); ***OR***
	+ A rehabilitation center under MassHealth 130 CMR 430.000; ***OR***
	+ A chronic disease and rehabilitation inpatient hospital under MassHealth 130 CMR 435.000; ***OR***
	+ An outpatient hospital services under MassHealth 130 CMR 410.451
* Physical Therapy
	+ An individual Physical Therapist under MassHealth 130 CMR 432.404(A); ***OR***
	+ A home health agency participating under 130 CMR 403.000; ***OR***
	+ A group practice under MassHealth 130 CMR 432.404(A); ***OR***
	+ A rehabilitation center under MassHealth 130 CMR 430.000; ***OR***
	+ A chronic disease and rehabilitation inpatient hospital under MassHealth 130 CMR 435.000; ***OR***
	+ An outpatient hospital services under MassHealth 130 CMR 410.451
* Speech Therapy
	+ An individual Speech Therapist under MassHealth 130 CMR 432.404(C); ***OR***
	+ A speech/hearing center under MassHealth 130 CMR 413.000; ***OR***
	+ A home health agency participating under MassHealth 130 CMR 403.000; ***OR***
	+ A group practice under MassHealth 130 CMR 432.404(C); ***OR***
	+ A rehabilitation center under MassHealth 130 CMR 430.000; ***OR***
	+ A chronic disease and rehabilitation inpatient hospital under MassHealth 130 CMR 435.451; ***OR***
	+ An outpatient hospital services under MassHealth 130 CMR 410.000
* All Occupational Therapy services must be provided by a licensed Occupational Therapist or by a licensed Occupational Therapy Assistant under the supervision of a licensed Occupational Therapist
* All Physical Therapy services must be provided by a licensed Physical Therapist or by a licensed Physical Therapy Assistant under the supervision of a licensed Physical Therapist
* All Speech Therapy services must be provided by a licensed Speech Therapist

**Documents to be submitted:**

[ ]  Resume(s) for licensed therapist supervising field staff; AND

[ ]  MassHealth award letter indicating your agency is established as a Group Practice (130 CMR 432.404); ***OR***

[ ]  MassHealth award letter indicating that your agency is established as a home health agency (130 CMR 403.000); ***OR***

[ ]  DPH Clinic License indicating the therapies you are authorized to provide (105 CMR 140.000); ***OR***

[ ]  DPH Speech and Hearing Center License 130 CMR 413.000; ***OR***

[ ]  MassHealth award letter indicating your agency is established as either a chronic disease and rehabilitation inpatient hospital; ***OR***

[ ]  MassHealth award letter indicating your agency is established as outpatient hospital services; OR

[ ]  American Speech-Language-Hearing Association (ASHA) Certificate

**THERAPY SERVICES KEY STAFF CONTACT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Title | Email | Phone |
|       | Contract Manager |       |       |
|       | Billing |       |       |
|       | Referral |       |       |
|       | Emergency On-Call |       |       |

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| [ ]  **TRANSPORTATION** - ORGANIZATION |

Conveyance of Participants by vehicle from their residence to and from the site of Waiver services and other community services, activities and resources, including physical assistance to Participants while entering and exiting the vehicle.

**REQUIREMENTS:**

* An organization engaged in the business of transporting persons with disabilities must:
	+ Ensure that vehicles are leased or controlled by the provider
	+ Maintain worker’s compensation insurance for drivers and monitors
	+ Employ drivers that are at least 19, have a valid driver’s license and 3 years driving experience
	+ Ensure vehicles are insured and liability insurance documentation is provided
	+ Ensure vehicles are registered with the Massachusetts Registry of Motor Vehicles (RMV)
	+ Ensure that accessible vehicles are equipped with safety equipment to secure wheelchairs
* Vehicle maintenance (including age of vehicle, capacity, seatbelts, list of safety equipment, air conditioning/heating) must be certified for each vehicle
* RMV inspection for each vehicle
* Completed log indicating that lifts are cycled daily for vehicles with lifts
* Inspection of vehicles that demonstrates:
	+ First Aid kits
	+ Snow tires in the winter
	+ 2-Way communication

**Documents to be submitted:**

[ ]  Organization policy on Driver Safety Training

[ ]  Company Hiring Policy

[ ]  Fare Schedule

[ ]  Vehicle Log outlining vehicle details: make, model, year, passenger capacity and vehicle type (i.e. passenger, van or chair car)

[ ]  Proof of vehicle insurance/registration for each vehicle outlined on the vehicle log

[ ]  (2) letters of reference from a current state agency funding source or a health insurance company

**KEY STAFF CONTACT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Title | Email | Phone |
|       | Contract Manager |       |       |
|       | Billing |       |       |
|       | Referral |       |       |
|       | Emergency On-Call |       |       |

1. **CERTIFICATION**

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity, duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

**Provider signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(signature and date stamps, or the signature of anyone other than the provider or a person legally authorized to sign on behalf of a legal entity, are not acceptable)

|  |  |
| --- | --- |
| **Printed legal name of provider:** |       |
| **Printed legal name of individual signing:**(if the provider is an entity) |       |
| **Date:** |       |

**MAIL ALL COMPLETED HCBS ENROLLMENT FORMS AND SUBMISSIONS TO:**

University of Massachusetts Medical School

Disability & Community Services

HCBS Provider Network Administration Unit

333 South Street

Shrewsbury, MA 01545