For office use only

Date received:

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Commonwealth of Massachusetts

EOHHS

www.mass.gov/masshealth

MassHealth Home and Community-Based

Services (HCBS) Waiver Provider

Application

If you have questions, contact: UMass Provider Network Administration

Unit • 1-855-300-7058 • ProviderNetwork@umassmed.edu

1. Provider name (please print)

2. Provider doing business address (for self employed provider please

enter self employed address)

3. City 4. State 5. Zip code (enter 9-digit zip code, if known)

6. Legal entity name

7. Legal entity street address

8. City 9. State 10. Zip code (enter 9-digit zip code, if known)

11. Telephone number (daytime) 12. Cellular telephone number (optional)

13. Fax number (if available) 14. E-mail address (please print)

15. Tax ID number or SSN 16. Contact person (please print) 17. Telephone

number of contact person

18. Do you currently have any Medicaid provider numbers (in addition to

the one you are applying for

with this application)? yes no

Other (specify) and #: Other (specify) and #:

19. Has there been any disciplinary action against you by any licensing

boards or certification bodies? yes no

If “yes,” please explain on a separate signed, dated piece of paper

attached to this application.

20. Have you ever been excluded from participation in the Medicaid or

Medicare program? yes no

If “yes,” please explain on a separate signed, dated piece of paper

attached to this application.

21. Type of ownership (Check one.)

 01—individual applicant (sole owner) 02—partnership 03—nonprofit

organization

 04—government entity 05—corporation 06—trust

 07—other (specify):

22. Indicate the services that you are applying to provide.

adult companion

assisted living services

chore services

community/residential family

training

day services

home health aide

homemaker

independent living supports

individual support/

community habilitation

occupational therapy

peer support

personal care

physical therapy

prevocational services

skilled nursing

supported employment

supportive home care aide

respite

specialized medical equipment

speech therapy

transportation

(over )

APP-HCBS (01/13)

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HCBS waiver provider application certification

Please Read Carefully and Sign

This is an application to be a provider in the MassHealth program. This

application will become part of, and is incorporated

by reference into, the provider agreement between this applicant and

MassHealth. The applicant should make and keep

a copy of this provider application as a record before submitting a

signed original to MassHealth. MassHealth will retain

this provider application for its records. Moreover, the applicant should

understand that it has a continuing obligation to

inform MassHealth of any change in the information submitted on or with

the provider application within 14 days of the

date on which the applicant becomes aware of such change.

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’s 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 individual signing (if the provider

is a legal entity)

Date

Printed legal name of provider

Title

Send your completed application to:

University of Massachusetts Medical School

Disability and Community Services

HCBS Provider Network Administration Unit

333 South Street

Shrewsbury, MA 01545

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