MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

MassHealth Home and Community-Based Services (HCBS) Waiver Provider Application

For office use only
Date received:
_____/_____/_____

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

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 provider

Printed legal name of individual signing (if the provider is a legal entity)

Title

Date

► **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

Clear Print