MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth Home and Community-Based Services Provider Application for ABI/MFP Waivers

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. Email address (please print)	
15. Tax ID number or SSN	16. National Provider Identifier (NPI)	
17. Contact person (please print)		18. Telephone number of contact person

19. 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 #: _____

Other (specify) and #: _____

20. 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.

21. 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.

22. Type of ownership (Check one.)

☐ 01–individual applicant (sole owner)
☐ 02–partnership
☐ 03–nonprofit organization
☐ 04–government entity
☐ 05–corporation
☐ 06–trust
☐ 07–limited liability company
☐ 08–other (specify): _____

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

☐ adult companion
☐ assisted living services
☐ assistive technology – devices
☐ assistive technology – evaluation & training
☐ chore
☐ community based day supports
☐ community behavioral health support and navigation
☐ community/residential family training
☐ day services
☐ home delivered meals
☐ home health aide
☐ homemaker
☐ independent living supports
☐ individual support and community habilitation
☐ laundry
☐ occupational therapy
☐ orientation and mobility services
☐ peer support
☐ personal care
☐ physical therapy
☐ prevocational services
☐ respite
☐ shared home supports
☐ skilled nursing
☐ specialized medical equipment
☐ speech therapy
☐ supported employment
☐ supportive home care aide
☐ transportation

ABI/MFP 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

The form can either be signed traditionally and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.

_____ _____

Printed legal name of Provider

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

_____ ____/____/_____

Title

Date

Return your completed application by email or mail.

Email:
ProviderNetwork@UMassmed.edu

Mail:
ForHealth Consulting at UMass Chan Medical School
Disability and Community Services
HCBS Provider Network Administration Unit
333 South Street
Shrewsbury, MA 01545