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 #:
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

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

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