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

Money Follows the Person Demonstration — Provider Enrollment Checklist

See required documents outlined below to become a MassHealth Money Follows the Person Demonstration Provider.

Provider applicant name

I. PROVIDER APPLICANTS MUST SUBMIT:

- ☐ MassHealth Money Follows the Person Demonstration (MFP Demo) Provider Application
  https://www.mass.gov/doc/money-follows-the-person-provider-application/download
- ☐ MassHealth Money Follows the Person Provider Agreement and Acknowledgement of Terms of Participation for Money Follows the Person Demonstration Services
  https://www.mass.gov/doc/mfp-provider-agreement-and-acknowledgement/download
- ☐ MassHealth Trading Partner Agreement
  https://www.mass.gov/doc/masshealth-trading-partner-agreement/download
- ☐ Data Collection Form and Registration Instructions for Home and Community-Based Services (HCBS) Waivers and Money Follows the Person Demonstration
  https://www.mass.gov/doc/data-collection-form-and-registration-instructions-for-hcbs-and-mfp-demonstration-0/download
- ☐ Authorization for Electronic Funds Transfer (EFT) of MassHealth payments and either:
  - ☐ Voided check, **or**
  - ☐ Bank letter that includes your legal name on account, type of account, routing number, and account number
    https://www.mass.gov/doc/electronic-funds-transfer-eft-enrollmentmodification-form-for-home-and-community-based-services/download
- ☐ Massachusetts Substitute W-9
  https://www.mass.gov/doc/massachusetts-substitute-w-9-form-1/download
- ☐ Provider Enrollment Checklist
- ☐ Federally required disclosure form
  https://www.mass.gov/doc/federally-required-disclosures-form-for-entities-pe-frd-e-0/download
  https://www.mass.gov/doc/federally-required-disclosures-form-for-individual-practitioners-pe-frd-in/download
- ☐ 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
- ☐ Describe your experience of the position as well as your experience working with individuals with disabilities, elders, or both. This should include staff orientation, ongoing staff development activities, training, and ongoing supervision to ensure all staff are trained and managed.
- ☐ Additional requirements outlined in Service Specific Requirements Section IV

II. GEOGRAPHICAL, LANGUAGE, AND POPULATION CAPACITY TO PROVIDE SERVICES

A. Please check off the **regions** where you are willing to provide services:
(See Appendix 1 for a list of municipalities by region or county)

☐ Boston/Metro ☐ Central ☐ Southeast/Cape/Islands ☐ Northeast ☐ Western

B. Please check off the **counties** where you are can provide services:
See map for a list of Massachusetts counties https://www.sec.state.ma.us/divisions/cis/download/maps/County_Map.pdf

☐ Barnstable	☐ Berkshire	☐ Bristol	☐ Dukes	☐ Essex
☐ Franklin	☐ Hampden	☐ Hampshire	☐ Middlesex	☐ Nantucket
☐ Norfolk	☐ Plymouth	☐ Suffolk	☐ Worcester	

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

List towns: _____

_____

_____

C. Language: In addition to English, please indicate any languages you or your organization's providers can communicate fluently, including American Sign Language (ASL):

Languages: _____

_____

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

☐ Individuals with Acquired Brain Injury
☐ Individuals with physical disabilities
☐ Individuals with mental health disorders
☐ Elderly individuals
☐ Individuals with intellectual disabilities
☐ Individuals with substance use disorders

E. Current State Contract: Please check off all state agencies/offices you currently have contracts with:

☐ Massachusetts Rehabilitation Commission (MRC)
☐ Department of Public Health (DPH)
☐ Department of Children & Families (DCF)
☐ Human Service Transportation (HST) Broker System
☐ Department of Developmental Services (DDS)
☐ Department of Mental Health (DMH)
☐ MassHealth
☐ Other: _____

_____

III. PROVIDER REQUIREMENTS

Each participating provider must sign a MassHealth Provider Agreement agreeing to follow 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):
  130 CMR 450.000: Administrative and Billing Regulations | Mass.gov
- MassHealth Rates for Home and Community Based Waiver Regulations (101 CMR 359):
  101 CMR 359.00: Rates for Home and Community-Based Services Waivers | Mass.gov
- MassHealth Home and Community Based Waiver Services (130 CMR 630):
  130 CMR 630.000: Home- and Community-Based Services Waiver | Mass.gov
- MassHealth Rates for Money Follows the Person Demonstration Services
  101 CMR 356.00: Rates for Money Follows the Person Demonstration Services | Mass.gov

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

- Policy for Acquired Brain Injury Residential Habilitation (ABI-RH) and Moving Forward Plan Residential Supports (MFP-RS) Waivers: Home- and Community-Based Services (HCBS) Waivers: ABI and MFP Information for Providers | Mass.gov (Scroll down to the section, DDS Waiver Policies)
- Policy for Acquired Brain Injury Non-Residential Habilitation (ABI-N) and Moving Forward Plan Community Living (MFP-CL) Waivers: Home- and Community-Based Services (HCBS) Waivers: ABI and MFP Information for Providers | Mass.gov (Scroll down to the section, MassHealth/Massachusetts Rehabilitation Commission Standards.)
- MRC Community Living Division Provider Manual: https://www.mass.gov/files/documents/2017/12/26/mrc-cl-practices-policies-procedures-2016.pdf
- Tuberculosis Disease Screening Tool to be used for staff screening requirements. https://www.mass.gov/lists/tuberculosis-information-for-health-care-providers-and-public-health

IV. SERVICE – SPECIFIC REQUIREMENTS

INSTRUCTIONS: Please submit all the related documentation for each service type that your organization is applying for. Organizations applying for multiple service types will be credentialed for each type.

☐ Assistive Technology Evaluation and Training Services
☐ Assistive Technology Devices
☐ Community Engagement and Navigation

☐ **Assistive Technology Evaluation and Training Services (ATE)**—Organization and Individual
This service has two components: Assistive Technology devices and Assistive Technology (AT) evaluation and training. Providers of AT Evaluation and Training may also supply AT devices.

These components are defined as follows:

Assistive Technology devices – an item, piece of equipment, or product system that is used to develop, increase, maintain, or improve functional capabilities of participants, and to support the participant to achieve goals identified in their Plan of Care. Assistive Technology devices can be used to enable the participant to engage in telehealth. Assistive Technology devices can be acquired commercially or modified, customized, engineered or otherwise adapted to meet the individual's specific needs, including design and fabrication. In addition to the cost of Assistive Technology device purchase, lease, or other acquisition costs, this service component covers maintenance and repair of Assistive Technology devices and rental of substitute Assistive Technology devices during periods of repair. This service includes device installation and set up costs but excludes installation and set-up and ongoing provision fees related to internet service. This service includes purchase, lease, or other acquisition costs of cell phones, tablets, computers, and ancillary equipment necessary for the operation of the Assistive Technology devices that enable the individual to participate in telehealth. These devices are not intended for purely diversional/recreational purposes.

Assistive Technology evaluation and training – the evaluation of the Assistive Technology needs of the participant, i.e. functional evaluation of the impact of the provision of appropriate Assistive Technology devices and services to the participant in the customary environment of the participant; the selection, customization and acquisition of Assistive Technology devices for participants; selection, design, fitting, customization, adaption, maintenance, repair, and/or replacement of Assistive Technology devices; coordination and use of necessary therapies, interventions, or services with Assistive Technology devices that are associated with other services contained in the Plan of Care; training and technical assistance for the participant, and, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Assistive Technology must be authorized by the Case Manager as part of the Plan of Care. The Case Manager will explore with the participant/legal guardian the use of the Medicaid State Plan. Waiver funding shall only be used for assistive technology that is specifically related to the functional limitation(s) caused by the participant's disability. The evaluation and training component of this service may be provided remotely via telehealth based on the professional judgment of the evaluator and the needs, preferences, and goals of the participant as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment.

continued ➤

Assistive Technology must meet the Underwriter's Laboratory and/or Federal Communications Commission requirements, where applicable, for design, safety, and utility.

There must be documentation that the item purchased is appropriate to the participant's needs. Any Assistive Technology item that is available through the State Plan must be purchased through the State Plan; only items not covered by the State Plan may be purchased through the Waiver.

Participants may not receive duplicative devices through this service and either the Transitional Assistance Service or the Specialized Medical Equipment Service.

Provider Requirements:

- Assistive technology provider staff and individual providers must have either
  - a bachelor's degree in a related technology field and at least one year of proven experience providing adaptive technological assessment or training; ***or***
  - a bachelor's degree in related health or human services field with at least two years of proven experience conducting adaptive technological assessment or training; ***or***
  - three years of proven experience providing adaptive technological assessment or training
- Knowledge of and experience in evaluating the needs of an individual with a disability, including functionally evaluating the individual in the individual's environment.
- Knowledge of and experience in buying or helping acquire assistive technology devices by individuals with devices.
- Knowledge of or experience or both in selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.
- Knowledge of or experience or both in coordinating and using other therapies, interventions, or services with assistive technology devices.
- Knowledge of or experience or both in training or providing technical help for an individual with disabilities, or when applicable, the family of an individual with disabilities or others who provide support to the individual.
- Knowledge of or experience or both in training or providing or both technical help for professionals or other individuals who offer services to or are involved in the major life functions of individuals with disabilities.

Documents to be submitted by organizations:

☐ One page description of experience being an assistive technology or similar service provider
☐ Copy of current assistive technology accreditation or therapy license

Documents to be submitted by individuals:

☐ One page description of experience as an assistive technology or similar service provider
☐ Evidence of a bachelor's degree or proof of the number of years' experience providing adaptive technological assessment or training
☐ Copy of current assistive technology accreditation or therapy license

Key Staff Contact Information

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

continued ➤

☐ **Assistive Technology Devices (AT)** – Organization And Individual

Assistive Technology devices - an item, piece of equipment, or product system that is used to develop, increase, maintain, or improve functional capabilities of participants, and to support the participant to achieve goals identified in their Plan of Care. Assistive Technology devices can be used to enable the participant to engage in telehealth. Assistive Technology devices can be acquired commercially or modified, customized, engineered or otherwise adapted to meet the individual's specific needs, including design and fabrication. In addition to the cost of Assistive Technology device purchase, lease, or other acquisition costs, this service component covers maintenance and repair of Assistive Technology devices and rental of substitute Assistive Technology devices during periods of repair. This service includes device installation and set up costs but excludes installation and set-up and ongoing provision fees related to internet service. This service includes purchase, lease, or other acquisition costs of cell phones, tablets, computers, and ancillary equipment necessary for the operation of the Assistive Technology devices that enable the individual to participate in telehealth. These devices are not intended for purely diversional/recreational purposes.

Assistive Technology must be authorized by the Case Manager as part of the Plan of Care. The Case Manager will explore with the participant/legal guardian the use of the Medicaid State Plan. Waiver funding shall only be used for assistive technology that is specifically related to the functional limitation(s) caused by the participant's disability.

Assistive Technology must meet the Underwriter's Laboratory and/or Federal Communications Commission requirements, where applicable, for design, safety, and utility.

There must be documentation that the item purchased is appropriate to the participant's needs. Any Assistive Technology item that is available through the State Plan must be purchased through the State Plan; only items not covered by the State Plan may be purchased through the Waiver.

Participants may not receive duplicative devices through this service and either the Transitional Assistance Service or the Specialized Medical Equipment Service.

Provider Requirements:

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:

- Providers shall ensure that individual workers employed by the agency have been CORI checked and are able to perform assigned duties and responsibilities.
- Providers of assistive technology must ensure that all devices and accessories have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.
- In addition, providers licensed, certified, and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.

Documents to be submitted by organizations:

☐ One page description of experience being an assistive technology or similar service provider.
☐ DME provider must have documentation that they meet requirements in 130 CMR 409 OR if not a DME provider, a list of contracted manufacturers used for purchased products
☐ Copy of current accreditation letters if applicable
☐ Fee Schedule

Documents to be submitted by individuals:

☐ One page description of experience as an assistive technology or similar service provider
☐ Evidence of a bachelor's degree or years' experience (as indicated above) or both of providing adaptive technological assessment or training.

Key Staff Contact Information

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

☐ **Community Engagement and Navigation (CEN)** – Organization And Individual

The organization or individual provides outreach and support services to MFP Demonstration participants as they prepare to transition out of facilities and after they have transitioned. The CEN service ensures that participants have a way to experience different community settings and community services. The service also aims to increase the participant's comfort level with transitioning. The CEN service facilitates engagement with community options after the transition, providing continuity for these participants and addressing any challenges they may face once they are in the community.

Community Engagement and Navigation services may include accompaniment and transportation from facilities to community housing and service options; supporting service exploration and linkage; and assistance with connections to and engagement with community services.

Provider Requirements:

- Any not-for-profit organization or self-employed provider must be in the business of providing individual support and community habilitation or a similar service.
- All organization staff or self-employed providers should
  - – 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:

☐ Resume of program director and applicable license type(s) and number(s)
☐ One page description of experience of your agency's delivery of CEN or a similar service

Documents to be submitted by individuals:

☐ Two Letters from business references that describe the individual's work with a service like CEN that clearly demonstrates community-based work experience providing skills training services to people with disabilities.
☐ One page description of experience of your delivery of CEN or a similar service

Key Staff Contact Information

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

V. CERTIFICATION

I confirm under the pains and penalties of perjury that the information on this form and any statement that I attached has been reviewed and signed by me, and is true, accurate, and complete to the best of my knowledge. I also confirm 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 if I make false statements, leave out important information, or try to hide any significant details in this document, I may be subject to civil penalties or criminal prosecution.

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 entity)

Date

If you have questions, please contact the Home and Community Based Services (HCBS) Provider Network Administration Unit at (855) 300-7058 or ProviderNetwork@umassmed.edu

► **Return your completed form by email or mail to MassHealth.**

Email: ProviderNetwork@UMassmed.edu

Mail: Waiver Provider Network Administration
UMass Chan Medical School
PO Box 2672
Worcester, MA 01613

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