**Commonwealth of Massachusetts** Executive Office of Health and Human Services [www.mass.gov/masshealth](http://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

1. 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-](https://www.mass.gov/doc/electronic-funds-transfer-eft-enrollmentmodification-form-for-home-and-community-based-services/download) [services/download](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 informatio[n](https://www.mass.gov/regulations/101-CMR-35600-rates-for-money-follows-the-person-demonstration-services-0) [Proof of liability insurance and workers compensation insurance](https://www.mass.gov/regulations/101-CMR-35600-rates-for-money-follows-the-person-demonstration-services-0)

[Describe your experience of the position as well as your experience working with individuals with disabilities, elders, or both.](https://www.mass.gov/regulations/101-CMR-35600-rates-for-money-follows-the-person-demonstration-services-0) [This should include staff orientation, ongoing staff development activities, training, and ongoing supervision to ensure all staff](https://www.mass.gov/regulations/101-CMR-35600-rates-for-money-follows-the-person-demonstration-services-0) [are trained and managed.](https://www.mass.gov/regulations/101-CMR-35600-rates-for-money-follows-the-person-demonstration-services-0)

[Additional requirements outlined in Service S](https://www.mass.gov/regulations/101-CMR-35600-rates-for-money-follows-the-person-demonstration-services-0)pecific Requirements Section IV

1. GEOGRAPHICAL, LANGUAGE, AND POPULATION CAPACITY TO PROVIDE SERVICES
	1. 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

* 1. 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:

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

# Languages:

* 1. Population: Please select the population(s) which you have experience working with: Individuals with Acquired Brain Injury Elderly individuals

Individuals with physical disabilities Individuals with intellectual disabilities

Individuals with mental health disorders Individuals with substance use disorders

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

Massachusetts Rehabilitation Commission (MRC) Department of Developmental Services (DDS) Department of Public Health (DPH) Department of Mental Health (DMH)

Department of Children & Families (DCF) MassHealth

Human Service Transportation (HST) Broker System Other:

1. 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](https://www.mass.gov/regulations/130-CMR-450000-administrative-and-billing-regulations)

* 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](https://www.mass.gov/regulations/101-CMR-35900-rates-for-home-and-community-based-services-waivers?_gl=1%2A761e0%2A_ga%2AMTgyNDA5MjU0Ny4xNjk0Nzc5MzI2%2A_ga_MCLPEGW7WM%2AMTY5NjI3MDI3My4zLjEuMTY5NjI3MTU5NC4wLjAuMA)
* MassHealth Home and Community Based Waiver Services (130 CMR 630): [130 CMR 630.000: Home- and Community-Based Services Waiver | Mass.gov](https://www.mass.gov/regulations/130-CMR-630000-home-and-community-based-services-waiver?_gl=1%2A3s1ref%2A_ga%2AMTgyNDA5MjU0Ny4xNjk0Nzc5MzI2%2A_ga_MCLPEGW7WM%2AMTY5NjI3MDI3My4zLjEuMTY5NjI3MTcwNC4wLjAuMA)
* MassHealth Rates for Money Follows the Person Demonstration Services

[101 CMR 356.00: Rates for Money Follows the Person Demonstration Services | Mass.gov](https://www.mass.gov/regulations/101-CMR-35600-rates-for-money-follows-the-person-demonstration-services?_gl=1%2A24dcik%2A_ga%2AMTgyNDA5MjU0Ny4xNjk0Nzc5MzI2%2A_ga_MCLPEGW7WM%2AMTY5NjI3MDI3My4zLjEuMTY5NjI3MTc0Ny4wLjAuMA)

# [Waiver Policies established by the Department of Developmental Services (DDS) and Massachusetts Rehabilitation](https://www.mass.gov/regulations/101-CMR-35600-rates-for-money-follows-the-person-demonstration-services?_gl=1%2A24dcik%2A_ga%2AMTgyNDA5MjU0Ny4xNjk0Nzc5MzI2%2A_ga_MCLPEGW7WM%2AMTY5NjI3MDI3My4zLjEuMTY5NjI3MTc0Ny4wLjAuMA) [Commission (MRC)](https://www.mass.gov/regulations/101-CMR-35600-rates-for-money-follows-the-person-demonstration-services?_gl=1%2A24dcik%2A_ga%2AMTgyNDA5MjU0Ny4xNjk0Nzc5MzI2%2A_ga_MCLPEGW7WM%2AMTY5NjI3MDI3My4zLjEuMTY5NjI3MTc0Ny4wLjAuMA)

* [Policy for Acquired Brain Injury Residential Habilitation (ABI-RH) and Moving Forward Plan Residential Supports (MFP-RS) Waivers:](https://www.mass.gov/regulations/101-CMR-35600-rates-for-money-follows-the-person-demonstration-services?_gl=1%2A24dcik%2A_ga%2AMTgyNDA5MjU0Ny4xNjk0Nzc5MzI2%2A_ga_MCLPEGW7WM%2AMTY5NjI3MDI3My4zLjEuMTY5NjI3MTc0Ny4wLjAuMA)

[Home- and Community-Based Services (HCBS) Waivers: ABI and MFP Information for Providers | Mass.gov](https://www.mass.gov/info-details/home-and-community-based-services-hcbs-waivers-abi-and-mfp-information-for-providers) (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](https://www.mass.gov/info-details/home-and-community-based-services-hcbs-waivers-abi-and-mfp-information-for-providers) (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>
1. 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.

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 |  |  |  |

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 (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 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

Mail all completed HCBS Enrollment forms and submissions to:

ForHealth Consulting at UMass Chan Medical School Disability and Community Services

HCBS Provider Network Administration Unit 333 South Street

Shrewsbury, MA 01545-4169

Fax: 774-455-5102