MEDICAID
AGED AND DISABLED PROVIDER
Certification Application
For Home and Community Based Service (HCBS)

Part 1. Demographic Information

Check **one** that applies. Complete a new form for each site and/or service.

□ Homemaker Agency □ Case Management Agency

Check one:

□ New Applicant
□ Additional Service
□ Continuing Certification

_____
Legal Name of Agency

_____
DBA (Doing Business As) if applicable

_____
Street Address (If additional service locations, please submit a new form for each location)

_____
Mailing Address

_____
City

(___)_____(___)_____
Phone Fax E-Mail Address

_____

_____
Names of Counties you intend to serve or currently serve.

Please document hours of operations: _____

_____/_____
Administrator/Director Printed Name Signature

_____
Contact Person / Print Name Title Date of Application

Part 2. In Addition to the completion of the Provider Application, the agency must comply with the following policy:

PROVIDER ENROLLMENT AND CERTIFICATION REQUIREMENTS

If a Case Management Agency (CMA), Homemaker Agency (HMA), Medical Adult Day Care (MADC) Agency, or any interested party requests information about becoming a certified ADW provider, they will be referred to the ADW manual on the BMS Web site. After examining the manual, the interested party must request an on-site visit by the Bureau of Senior Services (BoSS) staff to assess the certification criteria (see 502.B.) and provide initial program training. If the interested party is an existing ADW provider agency in good standing, the certification review may be expedited. If the party meets certification criteria, BMS's claims agent, Unisys, will then be notified as part of the enrollment process.

A. ENROLLMENT

The BMS claims agent will provide the applicant with an enrollment packet, including the Provider Agreement. The applicant will return the Provider Agreement signed by an authorized applicant representative to the Bureau for Medical Services. An authorized representative from BMS will sign the Provider Agreement and return a copy to the applicant. BMS will forward a copy of the Provider Agreement to the BMS claims agent. Once this process has been completed, the claims agent will assign a provider number and send a letter informing the agency that it may begin providing and billing for ADW services. A copy of this letter is also forwarded to BoSS to allow for the inclusion on the BoSS Web site and the Freedom of Choice provider selection forms, by which members may choose a CMA and HMA.

B. CERTIFICATION

All providers must agree to abide by applicable federal and state laws, policy manuals, policy changes, and other documents that govern this program. Providers must also agree to subject themselves, their staff, and any and all records pertaining to member services to any audit, desk review, or other service evaluation that ensures compliance with billing regulations and program goals.

Additionally, new and current providers must meet and maintain the following requirements:

1. Provide adequate qualified personnel who meet minimum criteria for providers of the ADW Program and who meet applicable licensure and/or other credentialing and training criteria. Direct care service providers must have a Criminal Investigation Background check (CIB) completed. Refer to section 501.2.1 for specific CIB policy. Waiver providers are subject to the provisions of WV Code 15-2C-1 et seq., the Central Abuse Registry maintained by the WV State Police.

2. Maintain records that fully disclose the extent of the services provided and furnish information to BMS, or its representative, as may be requested.

3. Provide to BoSS the names of the counties the agency intends to serve and currently serves. Provider must have a permanently staffed office(s); if any office is not located in each county served, there must be at least one permanently staffed office to serve no more than eight (8) contiguous counties.

4. Maintain an agency quality assurance plan that is consistent with the Centers for Medicare & Medicaid's (CMS') quality framework and assurances. (See www.cms.hhs.gov/HCBS/downloads/qualityframework.pdf).

5. Office Criteria – There must be a physical facility(ies) for each office designated to serve no more than eight (8) contiguous counties; a post office box or commercial mailbox will not suffice. Each facility so designated must meet the following criteria:

a. Must be located within West Virginia.

b. Must have at least one entrance that is handicapped accessible to the public and accessible from the street and/or parking lot. Handicapped parking must be available.

c. Must maintain a telephone that is listed under the name and local address of the business. Exclusive use of a pager, answering service (including a telephone line that is shared with another business/individual), facsimile machine, cell phone, or answering machine does not constitute a primary business telephone but may be used after hours or for emergencies.

d. Must be open to the public at least forty (40) hours per week. Observation of state and federal holidays is at the provider's discretion.

e. Must contain space for securely maintaining member records. Appropriate medical documentation on each member must be kept by the ADW provider in the office that represents the county in which services are provided. See Common Chapter 700, ¶790 for more information on maintenance of records.

f. Must be identifiable to the public.

Personal Options has been incorporated into this section.

Part 3. Medicaid Waiver Provider's Statement of Assurances and Compliance.

Check off the assurances before signing. Signatures must be from the individual authorized to sign for the provider entity.

□ 1. Provider assures that the entity complies and will maintain compliance with all requirements as specified in this application, and all applicable state and federal statutes, regulations and licensure requirements for the approved service(s).

□ 2. Provider assures that the entity will provide only those Medicaid Home and Community Based Service(s) which have been authorized in accordance with the Provider Agreement and Certification requirements.

Authorized Signature: _____

Printed Name: _____

Title: _____

Date:_____

Submit the entire completed application, including the signed Statement of Assurances and Compliance, and all documentation for specified certification requirements by US Mail as directed in Part 4. of this application form.

Unsigned/Undated applications will be returned

Part 4. Certification Application for Home and Community Based Service (HCBS)
Review for Completion and Assignment

If you are a **new applicant or are requesting to provide an additional service** mail application and all supporting documents to:

West Virginia Bureau of Senior Services
Attention: Director of Medicaid Operations
1900 Kanawha Blvd., East
Charleston, WV 25305-0160

Forwarded for Review by: Director of Medicaid Operations

Signature

Print Name:

If you are a **current provider requiring continuing certification** mail application and all supporting documents to:

West Virginia Bureau of Senior Services
Attention: Director of Quality Assurance
1900 Kanawha Blvd., East
Charleston, WV 25305-0160

Forwarded for Review by: Director of Nursing

Signature

Print Name: