Application Checklist for Maryland Medical Assistance Program Application

FACILITY/ORGANIZATION BRAIN INJURY WAIVER

If you have any questions, please contact program staff at:
Denise Farmer - Phone: (410) 767-1444 - Email: denise.farmer@maryland.gov

A completed application will include the following:

- ❑ Completed and signed Facility/Organization Provider Application
- ❑ A copy of your facility/organization NPI printout from NPPES
- ❑ Completed and signed Disclosure of Ownership and Control
- ❑ Completed and signed Provider Agreement
- ❑ Any additional material including application addenda that may be required by specific programs.

FACILITY

Instructions for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

INSTRUCTIONS FOR COMPLETING MARYLAND MEDICAID ENROLLMENT FORMS FOR FACILITIES/ORGANIZATIONS

Should you have any questions, please contact the Provider Enrollment Unit at (410) 767-5340

GENERAL INSTRUCTIONS	
1. Complete ALL items on the form unless otherwise instructed below. Failure to complete all required fields will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid. 2. Completion of signature fields is required. Initials or stamped signatures will not be accepted. 3. Please attach a copy of all requested documents. 4. These instructions do not need to be submitted with the application.	
MAIL TO	Unless instructed otherwise please mail completed enrollment applications and documentation to: The Department of Health and Mental Hygiene Office of Systems and Operations Administration Provider Enrollment P.O. Box 17030 Baltimore, MD 21203

TYPE OF REQUEST	
NEW ENROLLMENT	The facility/organization attempting to enroll in Maryland Medicaid has never been enrolled with Maryland Medicaid as a Fee for Service Provider.
RE-ENROLLMENT	The facility/organization has previously been enrolled with Maryland Medicaid as a Fee for Service Provider, but the facility/organization has been suspended or terminated from Maryland Medicaid.
RE-VALIDATION	The facility/organization is actively enrolled in Maryland Medicaid Fee for Service, but, due to required law, is verifying their information with Medicaid on or before their five year Maryland Medicaid enrollment anniversary date.
INFORMATION UPDATE	The facility/organization is actively enrolled in Maryland Medicaid and would like to change the information that is currently on file with Maryland Medicaid for the facility/organization.
APPLICATION SUBMITTED DATE	Date filling out the application.

FACILITY/ORGANIZATION INFORMATION	
NATIONAL PROVIDER IDENTIFIER (NPI)	Enter the unique site specific 10-digit NPI (Entity Type 2 Organization) of the facility/organization who will be providing services to Maryland Medicaid participants. To obtain a NPI, please visit the following website: https://nppes.cms.hhs.gov/NPPES/Welcome.do Please attach a printout from the previous website that lists the NPI information. If the facility/organization is an Atypical provider and is not eligible to obtain a NPI, leave this field blank and Maryland Medicaid will assign a NPI to you.
MARYLAND MEDICAL ASSISTANCE PROVIDER NUMBER	This is a unique provider number generated by Maryland Medicaid for each facility/organization. If you are a new enrollee, please leave this field blank. If you are an existing Maryland Medicaid facility/organization, please fill in your facility/organization's 9-digit Maryland Medicaid Number.
FACILITY/ORGANIZATION PROVIDER TYPE	Enter the two-digit code for the appropriate provider type from the listing provided at the end of these instructions.
TYPE OF PRACTICE	Enter the two-digit code for the appropriate type of practice from the listing provided at the end of these instructions.
SPECIALTY CODE	If applicable enter the two-digit code for the appropriate specialty code from the listing provided at the end of these instructions.
COUNTY CODE	Enter the two-digit code for the appropriate county code from the listing provided at the end of these instructions.
FACILITY/ORGANIZATION NAME	Enter the legal name of the facility/organization as it appears on federal tax documents.
DOING BUSINESS AS (NAME)	If the facility/organization operates under a different name than the legal name, enter that name here.
TAX IDENTIFICATION NUMBER	Enter the 9-digit tax identification number of the facility/organization.

Instructions for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

NAME OF TAX IDENTIFICATION NUMBER OWNER	Enter the name to which the tax identification number of the facility/organization is assigned.
MEDICARE PROVIDER NUMBER	If you participate in Medicare, please list the provider number that has been assigned to you.
MEDICARE FISCAL YEAR END DATE	Complete this field if the facility/organization is a nursing facility or hospital.
TELEPHONE NUMBER	Enter the best number to reach the facility/organization or contact person who can speak on behalf of the facility/organization regarding Maryland Medicaid participation.
E-MAIL ADDRESS	Enter the e-mail address of the facility/organization or contact person who can speak on behalf of the facility/organization regarding Maryland Medicaid participation.

CORRESPONDENCE INFORMATION	
CONTACT INFORMATION	If the application is being filled out on behalf of the facility/organization, enter the Name, Position/Title, Telephone and E-Mail address of the contact person who can speak on behalf of the facility/organization regarding Maryland Medicaid participation.
FACILITY/ORGANIZATION ADDRESS	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the primary address of the facility/organization.
CORRESPONDENCE ADDRESS	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the address where any letters or correspondence should be sent. This address must be kept up to date. Requests to Re-Validate or Update Information are NOT issued electronically and will be sent to this address.
PAY TO ADDRESS	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the address where any paper checks and paper remittance advices should be sent.
ELECTRONIC CORRESPONDENCE	If you prefer to receive electronic correspondence and Remittance Advice through an established eMedicaid account, check Yes.

LICENSE/PERMIT INFORMATION If applicable attach a copy of each license or certificate that is listed.	
CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) NUMBER*	Enter your CLIA ID Number, beginning effective date, and expiration date.
DRUG ENFORCEMENT ADMINISTRATION (DEA)	Enter your Drug Enforcement Administration number if applicable.
HOSPITAL FACILITY LICENSE	Enter your Office of Health Care Quality (OHCQ) issued hospital license number, beginning effective date, and expiration date.
MARYLAND LABORATORY PERMIT (MDLAB) OR LETTER OF PERMIT EXCEPTION NUMBER*	Enter your Office of Health Care Quality (OHCQ) issued MDLAB Number, beginning effective date, and expiration date. OR enter your OHCQ issued Letter of Permit Exception Number, beginning effective date, and expiration date.
NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAM (NCPDP)	Enter your NCPDP number if applicable.
PHARMACY	Enter your state issued license number if applicable.
RESIDENTIAL SERVICE AGENCY (RSA)	Enter your OHCQ issued license number if applicable.
OTHER	Enter any other license information as required.

***Medical laboratory providers:** Practitioners and other providers that perform medical laboratory services **MUST COMPLETE** and **SUPPLY** a copy of their CLIA and MDLAB Permit/Letter of Permit Exception. Out-of-state providers that do not receive specimens originating in Maryland do not have to supply Maryland certification information but do have to state that they do not receive specimens originating in Maryland. Practitioners providing laboratory services to OTHER THAN THEIR OWN PATIENTS MUST enroll as medical laboratory providers.

Instructions for Maryland
Medical Assistance Program Application
FACILITY/ORGANIZATION

ADDITIONAL INFORMATION	
FACILITY/ORGANIZATION INFORMATION	If the facility/organization is affiliated with a healthcare institution or medical school, please fill in the required fields and attach the required documentation.
LABORATORY INFORMATION	Answer the three questions listed in this section.
INSTITUTIONAL BED DATA	Complete all fields as appropriate for your provider type.
DIALYSIS FACILITIES	Complete this section if applicable.
AUTHORIZATION	Please have the administrator or authorized professional representative sign and date the application.
DISCLOSURE OF OWNERSHIP AND CONTROL	Maryland Medicaid is required to obtain disclosures on ownership and control from disclosing entities, fiscal agents, and managed care entities. Please fill out the six (6) sections and sign and date the Disclosure of Ownership and Control addendum. Failure to complete all required sections will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid.
PROVIDER AGREEMENT	Failure to complete the provider agreement will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid.
PROVIDER ADDENDUM	If applicable to your provider type, please complete the attached addendum.

Instructions for Maryland
Medical Assistance Program Application
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PROVIDER TYPE CODES					
1915(i) WAIVER	89	EPSDT THERAPEUTIC NURSERY	52	MEDICAL DAY CARE - CHILDREN	43
ADAA CERTIFIED PROGRAM	50	FREESTANDING BIRTH CENTERS	31	MENTAL HEALTH CASE MANAGEMENT PROVIDER	CM
AMBULANCE COMPANY	T1	FREESTANDING ONCOLOGY CENTERS	36	MENTAL HEALTH CLINIC	MC
AMBULATORY SURGERY CENTERS	39	HEALTHCHOICE MANAGED CARE ORGANIZATIONS	72	MOBILE TREATMENT PROGRAM	MT
AUDIOLOGY PROVIDERS	19	HMO/PACE	70	NURSING FACILITY	57
BRAIN INJURY WAIVER	86	HOME AND COMMUNITY BASED SERVICES, OTHER	40	OLDER ADULT WAIVER	76
CASE MANAGEMENT - NOT ELSEWHERE CLASSIFIED	81	HOME HEALTH AGENCIES	41	OXYGEN PROVIDERS	63
CLINIC, ABORTION	30	HOSPICE PROVIDERS	71	PARTIAL HOSPITALIZATION PROGRAM	MH
CLINIC, DRUG	32	HOSPITALS - ACUTE	1	PERSONAL CARE AGENCY	45
CLINIC, FAMILY PLANNING	33	HOSPITALS - ACUTE REHABILITATION	3	PERSONAL CARE MONITOR	47
CLINIC, FEDERALLY QUALIFIED HEALTH CENTER	34	HOSPITALS - CHRONIC	5	PHARMACY	RX
CLINIC, GENERAL	38	HOSPITALS - CHRONIC REHABILITATION	4	PORTABLE X-RAY	59
CLINIC, LOCAL HEALTH DEPARTMENT	35	HOSPITALS - SPECIAL OTHER ACUTE	6	PSYCHIATRIC REHAB SERVICES FACILITY	PR
CLINIC, RURAL	37	HOSPITALS - SPECIAL OTHER CHRONIC	7	REM PROVIDERS	87
DDA SERVICES PROVIDER	90	INTERMEDIATE CARE FACILITY - ADDICTION	55	RESIDENTIAL SERVICE/HOME HEALTH AIDE AGENCY	53
DIAGNOSTIC SERVICES, OTHER	60	INTERMEDIATE CARE FACILITY - ID	56	RESIDENTIAL TREATMENT CENTER	88
DIALYSIS FACILITIES	61	LABORATORIES	10	URGENT CARE CENTERS	8
DMS/DME PROVIDERS	62	LOCAL EDUCATION AGENCIES/LOCAL LEAD AGENCIES	91	VISION CARE PROVIDERS	12
EPSDT THERAPEUTIC BEHAVIORAL SERVICES	51	MEDICAL DAY CARE - ADULTS	42		

TYPE OF PRACTICE CODES			
HMO	50	PHARMACY, HOSPITAL BASED	23
NURSING HOME	10	PHARMACY, NURSING HOME BASED	24
PHARMACY, SINGLE STORE	20	PHARMACY, TAX SUPPORTED	25
PHARMACY CHAIN, 2-10 STORES	21	OTHER	99
PHARMACY CHAIN, 11+ STORES	22		

COUNTY CODE					
ALLEGANY	01	DORCHESTER	09	SOMERSET	19
ANNE ARUNDEL	02	FREDERICK	10	ST. MARY'S	18
BALTIMORE CITY	30	GARRETT	11	TALBOT	20
BALTIMORE COUNTY	03	HARFORD	12	WASHINGTON	21
CALVERT	04	HOWARD	13	WASHINGTON, DC	40
CAROLINE	05	KENT	14	WICOMICO	22
CARROLL	06	MONTGOMERY	15	WORCESTER	23
CECIL	07	PRINCE GEORGE'S	16	OTHER STATE	99
CHARLES	08	QUEEN ANNE'S	17		

PHARMACY SPECIALTY CODES		KIDNEY DISEASE PROGRAM	
HOME IV THERAPY	147	DIALYSIS FACILITY	K3
HOSPITAL OUTPATIENT PHARMACY	151	HOSPITAL-INPATIENT	K6
INSTITUTIONAL PHARMACY	156	HOSPITAL-OUTPATIENT	K5
MULTI-SPECIALTY PHARMACY	168	MEDICAL LABORATORY	K7
RETAIL CHAIN PHARMACY	202	PHARMACY	K2
RETAIL SINGLE PHARMACY	204	PHYSICIAN	K1
OTHER PHARMACY	184	OTHER (DENTAL, VISION)	K8

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Application for Participation in Maryland Medical Assistance Program

FACILITY/ORGANIZATION BRAIN INJURY WAIVER

IMPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION	**Unless Instructed Otherwise, Mail to:** The Department of Health and Mental Hygiene Office of Systems and Operations Administration Provider Enrollment P.O. Box 17030 Baltimore, MD 21203

TYPE OF REQUEST Please select one.			
☐ **NEW ENROLLMENT** (Applicant has never enrolled with Maryland Medical Assistance)	☐ **RE-ENROLLMENT** (Provider is currently excluded/terminated from the Maryland Medicaid Program)	☐ **RE-VALIDATION** (Provider is enrolled and required to revalidate)	☐ **INFORMATION UPDATE** (Provider is enrolled and updating information to the provider's file)
Application Submitted Date			

FACILITY/ORGANIZATION INFORMATION	
NPI (Organization)	Maryland Medical Assistance Provider Number (If existing provider)
Provider Type (Refer to instructions for appropriate codes.) **86**	Type of Practice (Refer to instructions for appropriate codes.) **99**
Specialty Code (Refer to instructions for appropriate codes.)	County Code (Refer to instructions for appropriate codes.)
Facility/Organization Name	Doing Business As (DBA)
Tax Identification Number	Name of Tax Identification Number Owner
Medicare Provider Number	Medicare Fiscal Year End Date
Telephone Number + extension	E-Mail Address

CONTACT INFORMATION The contact name and email relate to the person who can answer questions about the information provided in this packet.	
Contact Name	Position/Title
Telephone	E-Mail Address
FACILITY/ORGANIZATION ADDRESS	
Street Address	Suite/Department/Floor
City / State	Zip Code (9 Digit)
Telephone Number + extension	Fax Number

Application for Participation in Maryland Medical Assistance Program
FACILITY/ORGANIZATION

CORRESPONDENCE ADDRESS Please indicate where letters and claims forms, if any, should be sent.		
Street Address	Suite/Department/Floor	
City	State	Zip Code (9 Digit)
Telephone Number + extension	Fax Number	

PAY TO ADDRESS Please indicate where checks & remittance statements should be sent.		
Street Address	Suite/Department/Floor	
City	State	Zip Code (9 Digit)
Telephone Number + extension	Fax Number	

ELECTRONIC CORRESPONDENCE		
Would you prefer to receive electronic correspondence in lieu of paper when available?	☐ YES	☐ NO

LICENSE/PERMIT INFORMATION A copy of the license or certificate from the appropriate board or authority must be included as an attachment to this application. If more space is needed, please attach additional pages.				
CLIA	State Issued	License Number	Date Issued	Expiration Date
DEA	State Issued	License Number	Date Issued	Expiration Date
Hospital Facility License	State Issued	License Number	Date Issued	Expiration Date
MDLAB	State Issued	License Number	Date Issued	Expiration Date
NCPDP	State Issued	License Number	Date Issued	Expiration Date
Pharmacy	State Issued	License Number	Date Issued	Expiration Date
RSA	State Issued	License Number	Date Issued	Expiration Date
Other	State Issued	License Number	Date Issued	Expiration Date

Application for Participation in Maryland Medical Assistance Program
FACILITY/ORGANIZATION

FACILITY/ORGANIZATION INFORMATION		
If your facility/organization is affiliated with a health care institution or medical school, please enter the name and full address of the institution or school, your title and a brief explanation of your group's duties.		☐ NOT APPLICABLE
Name of Institution		
Title	Duties	
Street Address	Suite/Department/Floor	
City	State	Zip Code (9 Digits)
Certification Date	Certification Number	

Is your facility/organization salaried by the above institution?	☐ YES	☐ NO
If you are a M.D. or D.O. will you be dispensing pharmaceuticals other than samples (as pharmacy)?	☐ YES	☐ NO
If you are an O.D., are you practicing optometry exclusively?	☐ YES	☐ NO
Or optometry as well as preparing and dispensing eyeglasses (as an optician)?	☐ YES	☐ NO
Is your facility/organization operating a Local Health Department Clinic?	☐ YES	☐ NO
Is your facility/organization operating a Freestanding Clinic?	☐ YES	☐ NO

LABORATORY INFORMATION

Reimbursement for medical laboratory services you provide to eligible recipients are dependent on answering the following questions and supplying copies of CLIA Certificate and, when required, Maryland Laboratory Permits or Letters of Permit Exception. Practitioner providers cannot be reimbursed for services referred to medical laboratories or other practices. Those laboratories or practices must bill.

Do you provide medical laboratory services for your own patients?	☐ YES	☐ NO
Do you provide medical laboratory services for other than your own patients?	☐ YES	☐ NO
Do you receive specimens that are obtained from other sites located in Maryland?	☐ YES	☐ NO

All Maryland laboratories are required to have a Maryland Laboratory Permit or Letter of Permit Exception Number (§Health General Article §17-205, Annotated Code of Maryland) and CLIA Certificate Number (Clinical Laboratory Improvement of 1988 Public Law 100-578) to perform laboratory services. Out-of-state providers are only required to provide their CLIA Certificate Number, if they do not receive specimens that originate in Maryland.

Application for Participation in Maryland Medical Assistance Program
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INSTITUTIONAL BED DATA	
Acute Inpatient (INP) Number of Beds	Assisted Living Facilities
Chronic Hospital (CHB) Number of Beds	Intellectual Disability (ID)
Number of Beds Nursing Facility (NF) Number of Beds	Other (OTH) Number of Beds

DIALYSIS FACILITIES Please attach a copy of letter with assigned Medicare Provider Number and a copy of the letter(s) from your intermediary showing all approved services. You will be paid ONLY for the services that are rendered and appear in this/these letter(s).
Medicare Provider Number

AUTHORIZATION

I, the administrator or authorized professional representative of this facility/organization, hereby affirm that this information given by me is true and complete to the best of my knowledge and belief. I understand that if I or my facility/organization is salaried by a hospital or other institution for patient care, that I or my group will not bill the Maryland Medical Care Program for those services for which I or my facility/organization is salaried.

Signature of Administrator or Authorized Professional Responsible for the Quality of Patient Care (No stamps) **Date**

Name of Administrator or Authorized Professional Responsible for the Quality of Patient Care (Type or Print) **Date**

Application for Participation in Maryland Medical Assistance Program
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DISCLOSURE OF OWNERSHIP AND CONTROL

Completion is required by 42 CFR Part 455.104. Failure to provide the information requested will cause the application to be returned. Attach additional pages as needed.

SECTION 1:

Disclosing Entity/Applicant (Facility/organization named on page 1 of this application)

Name		NPI (Organization)
Address – Street	City & State	Zip Code (9 Digits)
Federal Employer Identification Number (FEIN)		

Ownership in Applicant (Has direct or indirect ownership interest[1] of 5% or more. Include familial relationship to the Applicant and other Owners (spouse, parent, child, sibling), if any. The address for corporate entities must include every business address. See 42 CFR Part 455.104 (b)(1)(i) for more information.)

Name of Individual or Entity	% of Ownership	NPI (Individual)
Address (Home Address if individual)	City & State	Zip Code (9 Digits)
SSN (if individual)	Federal Employer Identification Number (if entity)	
Date of Birth (MM/DD/YYYY)	Familial Relationship (if individual, if any)	

[1] A) "Ownership interest" means the possession of equity in the capital of, stock in, or of any interest in the profits of the disclosing entity.
B) "Indirect ownership interest" means any ownership interest in an entity that has ownership interest in the disclosing entity. The term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
C) "Determination of ownership or control percentage"

1) Indirect ownership interest – the amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

2) Person with an ownership or control interest – in order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

SECTION 2:

Agents and Managing Employees (e.g. office manager, administrator, director or other individuals who exercise operational or managerial control over the day to day operations of the provider. If the applicant is a non-profit organization please include all board members, directors, and managers. Include familial relationship to the Applicant (spouse, parent, child, sibling), if any. If additional space is needed, copy form; all entries must be on the form.)

Name	Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship
Name	Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship
Name	Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship

SECTION 3:

Ownership in Other Disclosing Entities (ODE) (per 42 CFR, Part 455.104 (b)(3)) – (Complete if any identified in Section 1 has an ownership or control interest in ODE)

Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE

SECTION 4:

Ownership in Subcontractors (If the Applicant has an ownership or control interest of 5% or more in a subcontractor and an Owner of the Applicant also has an ownership or control interest in the subcontractor, complete the boxes below. If those identified in this Section have a familial relationship with a person with ownership or control interest in one of these subcontractors, complete Section 4).

Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number

SECTION 5:

Familial Relationship in Subcontractors (Complete if those identified in Section 3 have a familial relationship (parent, child sibling spouse))

Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship

SECTION 6:

Respond to these questions on behalf of:

1. The Applicant
2. All individuals and entities identified in Sections 1& 5.
3. Any entity in which the Applicant has a 5% or more ownership.

1. Have any of the individuals/entities (1,2 and 3) been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid Program in Maryland or in any other State, Medicare, or any other governmental or private medical insurance program?

☐ YES ☐ NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

2. Have any of the individuals/entities (1,2 and 3) ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any State?

☐ YES ☐ NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

3. Have any of the individuals/entities (1,2 and 3) ever had their business or professional license or certification, or the license of an entity in which they had an ownership interested over 5% ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any State?

☐ YES ☐ NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

4. Is there currently pending any proceedings that could result in the above stated sanctions for the individuals/entities (1, 2 and 3)?

☐ YES ☐ NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

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SIGNATURE AND AFFIRMATION
An application is not considered complete unless the applicant signs below. Failure to provide a signature will cause the application to be returned. I hereby affirm that this information is true and complete to the best of my knowledge and belief, and that the requested information will be updated as changes occur. I further certify that upon specific request by the Secretary of the Department of Health and Human Services, or the Maryland Department of Health and Mental Hygiene, full and complete information will be supplied within 35 days of the date of the request, concerning: A. The ownership of any subcontractor with which the Title XIX Provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000.00 and B. Any significant business transactions[2], occurring during the 5 year period ending on the date of such request, between the Provider and any wholly-owned supplier[3] or any subcontractor. **Authorized Signature** (No Stamps) **Date** **Position** (Type or Print)

[2] "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5 percent of the total operating expense of a provider.

[3] "Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g. a commercial laundry, a manufacturer of hospital bed, or a pharmaceutical firm).

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Provider Agreement for Participation in Maryland Medical Assistance Program

This Agreement (the "Agreement"), entered into between the Maryland State Department of Health and Mental Hygiene (the "Department") and

_____

(Provider Name)

the undersigned Provider or Provider Group and its members or Practitioner(s) (hereinafter called the "Provider"), is made pursuant to Title XIX and Title XXI of the Social Security Act, Health-General, Title 15, Annotated Code of Maryland and state regulations promulgated thereunder to provide medical, healthcare, and home- and community-based services and/or remedial care and services ("Service(s)") to eligible Maryland Medical Assistance recipients ("Recipient(s)"). On its effective date, this Agreement supersedes and replaces any existing contracts between the parties related to the provision of Services to Recipients.

I. THE PROVIDER AGREES:

A. To comply with all standards of practice, professional standards and levels of Service as set forth in all applicable federal and state laws, statues, rules and regulations, as well as all administrative policies, procedures, transmittals, and guidelines issued by the Department, including but not limited to, verifying Recipient eligibility, obtaining prior authorizations, submitting accurate, complete and timely claims, and conducting business in such a way the Recipient retains freedom of choice of providers. The Provider acknowledges his, her or its responsibility to become familiar with those requirements as they may differ significantly from those of other third party payor programs;

B. To maintain adequate medical, financial and administrative records that fully justify and describe the nature and extent of all goods and Services provided to Recipients for a minimum of six years from the date of payment or longer if required by law. The Provider agrees to provide access upon request to its business or facility and all related Recipient information and records, including claims records, to the Department, the Medicaid Fraud Control Unit (MFCU) of the Maryland Attorney General's Office, the U.S. Department of Health and Human Services, and/or any of their respective employees, designees or authorized representatives. This requirement does not proscribe record requirements by other laws, regulations, or agreements. It is the Provider's responsibility to obtain any Recipient consent required to provide the Department, its designee, the MFCU, federal employees, and/or designees or authorized representatives with requested information and records or copies of records. Failure to timely submit or failure to retain adequate documentation for services billed to the Department may result in recovery of payments for Services not adequately documented, and may result in the termination or suspension of the Provider from participation as a Medical Assistance provider.

1. Original records must be made available upon request during on-site visits by Department personnel or personnel of the Department's designee.

2. Copies of records must be timely forwarded to the Department upon written request;

C. To protect the confidentiality of all Recipient information in accordance with the terms, conditions and requirements of the health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and regulations adopted thereunder contained in 45 CFR 160, 162 and 164, and the Maryland Confidentiality of Medical Records Act (Md. Ann. Code, Health-General §§4-301 *et seq*.);

D. To provide services on a non-discriminatory basis and to hold harmless, indemnify and defend the Department from all negligent or intentionally detrimental acts of the Provider, its agents and employees. The Provider will not discriminate on the basis of race, color, national origin, age, religion, sex, disabilities, or sexual orientation;

E. To provide Services in compliance with the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and their respective accompanying regulations, and ensure that qualified individuals with disabilities are given an opportunity to participate in and benefit from its Services, including providing interpretive services for the deaf and hard of hearing when required;

F. To check the Federal List of Excluded Individuals/Entities on the Health and Human Services (HHS) Office of Inspector General (OIG) website prior to hiring or contracting with individuals or entities and periodically check the OIG website to determine the participation/exclusion status of current employees and contractors. To check the Federal System for Award Management (SAM) prior to hiring or contracting with individuals or entities and periodically check the SAM website to determine the participation/exclusion status of current employees and contractors. To check the Maryland Medicaid List of Excluded Providers and Entities prior to hiring or contracting with individuals or entities and periodically check the website to determine the participation/exclusion status of current employees and contractors. The Provider further agrees to not knowingly employ, or contract with a person, partnership, company, corporation or any other entity or individual that has been disqualified from providing or supplying services to Medical Assistance Recipients unless the Provider receives prior written approval from the Department;

G. To accept the Department's payments as payment in full for covered Services rendered to a Recipient. The Provider agrees not to bill, retain, or accept any additional payment from any Recipient. If the Department denies payment or requests payment from the Recipient, or if the Department denies payment or requests repayment because an otherwise covered Service was not medically necessary or was not preauthorized (if required), the Provider agrees not to seek payment from the Recipient for that Service. The Provider further agrees to immediately repay the Department in full for any claims where the Provider received payment from another party after being paid by the Department;

H. With the exception of prenatal care or preventive pediatric care, to seek payment from a Recipient's other insurances and resources of payment before submitting claims to the Department, which includes but is not limited to seeking payment from Medicare, private insurance, medical benefits provided by employers and unions, worker compensation, and any other third party insurance. If payment is made by both the Department and the Recipient's other insurance, the Provider shall refund the Department, within 60 days of receipt, the amount paid by the Department;

I. To accept responsibility for the validity and accuracy of all claims submitted to the Department, whether submitted on paper, electronically or through a billing service;

J. That all claims submitted under his, her or its provider number shall be for medically necessary Services that were actually provided as described in the claim. The Provider acknowledges that the submission of false or fraudulent claims could result in criminal prosecution and civil and administrative sanctions. This may include his, her or its expulsion from the Maryland Medical Assistance Program and/or referrals by the Department to the HHS OIG for expulsion from the Medicare program;

K. That if Provider is a physician, he or she will, upon request, submit the name and applicable licensure for each physician extender in his or her employment. The Provider is responsible for knowing and complying with the Maryland Medical Assistance Program's definition of an eligible physician extender and for providing supervision as required by the Maryland Medical Assistance Program;

L. That in case of a group provider, the individual Provider rendering the service shall include his or her own provider number, as well as the group provider number, on any claim;

M. To furnish the Department, within 35 days of the Department's request, full and complete information about:

1. The ownership of any subcontractor with who the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request;

2. Any significant business transaction between the Provider and any wholly-owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request; and

3. Any ownership interest exceeding 5 percent held by the Provider in any other Medical Assistance Provider;

N. That before the Department enters into or renews this Agreement, the Provider agrees to disclose the identity of any person who:

1. Has an ownership or control interest in the Provider, or is an agent or managing employee of the Provider; and

2. Has been convicted of a criminal offense related to that person's involvement in the Medicaid or Medicare programs;

O. To exhaust all administrative remedies prior to initiating any litigation against the Department;

P. Upon receipt of notification that the Provider is disqualified through any federal, state and/or Medicaid administrative action, to not submit claims for payment to the Department for Services performed after the disqualification date;

Q. Any excessive payments to a Provider may be immediately deducted from future Department payments to any payee with the Provider's tax identification number, at the discretion of the Department;

R. Continuation of this Agreement beyond the current term is subject to and contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the State legislature and/or federal sources. The Department may terminate this Agreement and the Provider waives any and all claim(s) for damages, effective immediately upon receipt of written notice (or any date specified therin) if for any reason the Department's funding from State and/or federal sources is not appropriated or is withdrawn, limited or impaired;

S. To comply with the Deficit Reduction Act of 2005 (DRA) employee education requirement imposed upon any entity, including any governmental agency, organization, unit, corporation, partnership or other business arrangement (including any Medicaid MCO), whether for profit or not for profit, which receives annual Medicaid Payments of at least $5,000,000.

T. For Provider Groups Only: The Provider Group affirms that it has authority to bind all member Providers to this Agreement and that it will provide each member Provider with a copy of this Agreement. The Provider Group also agrees to provide the Department with names and proof of current licensure for each member Provider as well as the name(s) of individual (s) with authority to sign billings on behalf of the group. The Provider Group agrees to be jointly responsible with any member Provider for contractual or administrative sanctions or remedies including, but not limited to reimbursement, withholding, recovery, suspension, termination or exclusion on any claims submitted or payment received. Any false claims, statements or documents, concealment or omission of any material facts may be prosecuted under applicable federal or state laws.

U. To notify the Department within five (5) working days of any of the following:

1. Any action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on a Provider's licenses, certifications, permits or staff privileges by any entity under which a Provider is authorized to provide Services including indictment, arrest, felony conviction or any criminal charge;

2. Change in corporate entity, servicing locations, mailing address or addition to or removal of practitioners or any other information pertinent to the receipt of Department funds; or

3. Change in ownership including full disclosure of the terms of the sales Agreement. When there is a change in ownership this Agreement is automatically assigned to the new owner, and the new owner shall, as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due, or become due to the Department, and such amounts may be withheld from the payment of claims submitted when determined. (NOTE: Section I.S.3 does not apply to Nursing Home Providers)

II. THE DEPARTMENT AGREES:

A. To reimburse the Provider for medically necessary Services provided to Recipients that are covered by the Maryland Medical Assistance Program. Services will be reimbursed in accordance with all Program regulations and fee schedules as reflected in the Code of Maryland Regulations or other rules, action transmittals or guidance issued by the Department; and

B. To provide notice of changes in Program regulations through publication in the Maryland Register.

III. THE DEPARTMENT AND PROVIDER MUTUALLY AGREE:

A. That except as specifically provided otherwise in applicable law and regulations, either party may terminate this Agreement by giving thirty (30) days notice in writing to the other party. After termination, the Provider shall notify Recipients, before rendering additional Services, that he or she is no longer a Maryland Medical Assistance participating Provider;

B. That the effective date of this Agreement shall be _____, provided that the Department verifies the information in the Provider's application. This Agreement shall remain in effect until either party terminates the Agreement (as described in Section III A). Following termination of this Agreement, the Provider must continue to retain records and reimburse the Maryland Medical Assistance Program for overpayments as described in this Agreement and as required by law, including but not limited to Maryland Health-General § 4-403;

C. That no employee of the State of Maryland, whose duties include matters relating to this Provider's Agreement, shall at the same time become an employee of the Provider without the written permission of the Department;

D. That this Agreement is not transferable or assignable;

E. That the Provider Enrollment Application submitted and signed by the Provider is incorporated by reference into this Agreement and is a part hereof as though fully set forth herein; and

		Susan J Tucker	
Provider Signature (No stamps)	Date	Department Authorization	Date
Provider Name (Type or Print)	Date	Assistant Attorney General	Date
Provider Address (Type or Print)			

Addendum for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

Should you have any questions regarding completing this addendum, please contact:
Denise Farmer - Phone: (410) 767-1444 - Email: denise.farmer@maryland.gov

Please include the following materials with your application:

- ❑ Copy of the Articles of Incorporation or Articles of Organization;
- ❑ Full legal name, DOB, and SSN of the facility's owners;
- ❑ Full legal name, DOB and SSN of individuals with as 5% or more direct or indirect ownership;
- ❑ Full legal name, DOB and SSN of board of directors;
- ❑ Copy of tax ID number letter (IRS Letter); and
- ❑ Site license, if applicable

****Please review and complete the attached document for the applicable service you will be rendering, and submit with your Medical Assistance Program Brain Injury Waiver application.****

Medicaid Home and Community Based Services Waiver for Individuals with Brain Injury (BI Waiver) Provider Application

Summary of Provider Requirements

Per COMAR 10.09.46, providers of BI Waiver services must submit documentation that supports the agency's adherence to the licensing, accreditation, and program requirements described on the following pages. In addition to the licensing requirements, providers that are not already CARF accredited for Brain Injury must submit evidence of the agency's history and expertise in serving individuals with brain injury.

History of serving individuals with brain injury for at least the past 2 years

- The number and percent of consumers served, who have a brain injury, served by the agency in the past two years

A program of specialized services appropriate for the needs of individuals with brain injury

- A program service plan that includes a description of the specialized programming offered to meet the needs of individuals with brain injury

Availability of licensed healthcare professionals with experiences in the provision of services to individuals with brain injury to supervise, train, or consult with program staff regarding the needs of waiver participants

- A list of licensed professionals, employed or contracted by the agency, who are trained to work with individuals with brain injury (include credentials and number of years of experience working with this population)

Provide an annual continuing education program approved by BHA for all staff working with waiver participants on the needs of individuals with BI that may include

(1) Types of brain injury;

(2) Behavioral, emotional, cognitive, and physical changes after brain injury; and

(3) Strategies for compensation and remediation of deficits caused by a brain injury;

- Providers should include curriculum outlines, credentials of trainer(s), frequency that training if offered, policy related to staff requirement for initial and annual/ on-going brain injury training.

Provider's Business Name:_____

Check Off the area(s) you intend to serve. You may provide services in multiple areas. This is for informational purposes only, and does not lock you into serving only the indicated areas.

❒ Allegany	❒ Caroline	❒ Frederick	❒ Montgomery	❒ Talbot
❒ Anne Arundel	❒ Carroll	❒ Garrett	❒ Prince George's	❒ Washington
❒ Baltimore City	❒ Cecil	❒ Harford	❒ Queen Anne's	❒ Wicomico
❒ Baltimore Co.	❒ Charles	❒ Howard	❒ Somerset	❒ Worcester
❒ Calvert	❒ Dorchester	❒ Kent	❒ St. Mary's	

Brain Injury Waiver Services to be provided by Agency

1- *Select the service(s) that agency intends to provide (Residential Habilitation, Day Habilitation, Supported Employment, and/or Individual Support Services).*
2- *For each service that the agency intends to provide, initial the descriptions of the service, indicating that you understand the covered services described, AND*
3- *Initial the licensing and training items that apply to your provider organization. Be sure to enclose supporting documentation for each license and training requirement.*

☐ Waiver Service: Residential Habilitation

I. Description of Service

____ Assistance with acquisition, retention, or improvement in skills related to activities of daily living and the social and adaptive skills necessary to enable the individuals to live in a non-institutional setting.

____ Waiver participants will receive this service at one of three levels, depending upon the participant's needs. The level of service will be documented in the waiver plan of service and must be authorized through BHA's Administrative Service Organization.

1. Minimum of 1:3 staff to participant ratio during the day and evening shifts and non-awake supervision during overnight shift or an awake staff person covering more than one site during the overnight shift.
2. Minimum of 1:3 staff to participant ratio during the day and evening shift and awake, on-site supervision during overnight shift.
3. Minimum of 1:1 staff to participant ratio during the day and evening shift and awake on-site supervision during overnight shift.

II. Licensing

____ Copy of current license(s) by the Department of Health and Mental Hygiene (Developmental Disabilities Administration) for Community Residential Services under COMAR 10.22.08 (for all units where waiver recipients could reside), and

____ Summary of Program's history, experience, and expertise in serving individuals with brain injury

OR

____ Copy of current Brain Injury Program Accreditation through the Rehabilitation Accreditation Commission (CARF)

III. Training and Credentialing

____ Summary of Provider brain injury training program for staff

☐ Waiver Service: Day Habilitation

I. Description of Service

____ Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regular basis, for one or more days per week.

____ Waiver participants will receive this service at one of three levels, depending upon the participant's needs. The level of service will be documented in the waiver plan of service and must be authorized through BHA's Administrative Service Organization.

1. Minimum of 1: 6 staff to participant ratio
2. Minimum of 1:4 staff to participant ratio
3. 1:1 staffing ratio

II. Licensing

____ Copy of current license(s) by the Department of Health and Mental Hygiene (Developmental Disabilities Administration) for Day Habilitation Services under COMAR 10.22.08, and

____ Summary of Program's history, experience, and expertise in serving individuals with brain injury

OR

____ Copy of current Brain Injury Program Accreditation through the Rehabilitation Accreditation Commission (CARF)

III. Training and Credentialing

____ Summary of Provider brain injury training program for staff

☐ Waiver Service: Supported Employment

I. Description of Service

____ Includes activities needed to support paid work by individuals receiving waiver services, including supervision and training.

____ Waiver participants will receive this service at one of three levels, depending upon the participant's needs. The level of service will be documented in the waiver plan of service and must be authorized through BHA's Administrative Service Organization.

1. Staff provides daily contacts to waiver recipient
2. Staff provides a minimum of 1 hour of direct support/ day
3. Staff provides continuous support for a minimum of 4 hours of service per day

II. Licensing

____ Copy of current license(s) by the Department of Health and Mental Hygiene (Developmental Disabilities Administration) for Vocational Program under COMAR 10.22.08, and

____ Summary of Program's history, experience, and expertise in serving individuals with brain injury

OR

____ Copy of current Brain Injury Program certification through the Rehabilitation Accreditation Commission (CARF)

OR

____Copy of approval as Mental Health Vocational Program from the Department of Health and Mental Hygiene under COMAR 10.21.28

III. Training and Credentialing

____Summary of Provider's brain injury training program for staff

☐ Waiver Service: Individual Support Services

I. Description of Service

____ Includes assistance provided to an individual to enable participation in the community, which may include, but are not limited to, supports involving: budgeting; medication administration; counseling; helping an individual to access and complete the individual's education; participating in recreational and social activities; accessing community services; grocery shopping; behavioral and other services and supports needed by the family of the individual; and developing relationships.

____ Waiver participants may receive up to eight hours per day of this service. The amount and duration of services will be documented in the waiver plan of service and must be authorized through BHA's Administrative Service Organization.

II. Licensing

____ Copy of current license(s) by the Department of Health and Mental Hygiene (Developmental Disabilities Administration) for Family and Individuals Support Services under COMAR 10.22.08, and

____ Summary of Program's history, experience, and expertise in serving individuals with brain injury

OR

____ Copy of current Brain Injury Program certification through the Rehabilitation Accreditation Commission (CARF)

III. Training and Credentialing

____Summary of Provider's brain injury training program for staff

GENERAL CONDITIONS FOR PROVIDER PARTICIPATION

Provider Initials

_____ 1. Meet all of the conditions for participation set forth in COMAR 10.09.46 regarding General Medical Assistance Provider Participation Criteria

_____ 2. Provide services in accordance with the requirements of the approved waiver proposal, the waiver regulations at COMAR 10.09.46, and all other relevant State, federal, and local laws and regulations

_____ 5. Provide waiver services as specified in a participant's plan of care.

_____ 6. Maintain detailed, written documentation of services rendered to waiver participants.

_____ 7. Agree to cooperate with required inspections, reviews, and audits by authorized governmental representatives.

_____ 8. Agree to provide and bill Medicaid for only those services preauthorized in the participant's waiver plan of care, which are provided after the participant's waiver enrollment.

_____ **9. Room and Board: Providers of Residential Waiver Services for Individuals with Brain Injury are expected to provide room and board to waiver participants. Room and Board is not a Medicaid reimbursable expense. Providers may require waiver participants to pay provider up to $420.00 monthly to cover the cost of room and board. Waiver Providers are expected to develop an agreement with the waiver participant to this affect. Additionally, waiver participants should maintain a minimum of $100.00 of their monthly income for personal needs.**

Provider Applicant's Signature attesting to accuracy of information provided in this application.

_____ Date: _____

Provider's Business Name: _____