

**MONTANA DEVELOPMENTAL DISABILITIES PROGRAM
 MEDICAID WAIVER QUALIFIED PROVIDER APPLICATION
 Current Provider**

This application is for existing Developmental Disabilities Program qualified providers to add services to a current contract with DDP. Qualified providers may deliver, or may coordinate the delivery of those Department-approved services meeting the standards outlines as defined in the waivers, subject to the financial limitations of the individual cost plans.

Applying to add services to a current DDP provider contract

Note: Please submit this application to the DDP Regional Manager in the region where the main administrative office of the provider is located.

Date of Application: _____

Name of director: _____

Agency Name: _____ **EIN:** _____

Street Address: _____ **City:** _____ **ZIP:** _____

Mailing Address: _____ **City:** _____ **ZIP:** _____

Phone # : _____ **Fax # :** _____ **E-mail :** _____

Service Location

Area to be Served (city, county, DDP region)

Location of Administrative Office

_____	_____
_____	_____
_____	_____

Type of [Legal Entity/Business Model](#) (check one and attach copy of proof of status)

- Limited Liability Company Not-for-Profit Corporation
 Limited Liability Partnership Other (specify) _____

Accreditation Category (check one and attach certificate or explanation, if applicable)

DDP does not require accreditation

- CARF The Council Other (specify) _____ N/A, not required

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Services to be provided by the Agency

Comprehensive Services Waiver 0208 [DEFINITIONS](#) [RATES](#) [QP STANDARDS](#)

Supports for Community Working and Living 1037 [DEFINITIONS](#) [RATES](#) [QP STANDARDS](#)

Children's Autism Waiver 0667 [DEFINITIONS](#) [RATES](#) [QP STANDARDS](#)

SERVICE CATEGORY FOR DEFINITIONS, RATES, & STANDARDS SEE THE SPECIFIC WAIVER LINK ABOVE THE TABLE	WAIVER NUMBER (S) PLEASE CHECK ALL THAT APPLY	DDP REGION (S) PLEASE INDICATE REGIONS 1-5
CHILDREN'S AUTISM TRAINING	<input type="checkbox"/> 0667	
PROGRAM DESIGN AND MONITORING	<input type="checkbox"/> 0667	
WAIVER-FUNDED CHILDREN'S CASE MANAGEMENT	<input type="checkbox"/> 0208 <input type="checkbox"/> 0667	
OCCUPATIONAL THERAPY	<input type="checkbox"/> 0208 <input type="checkbox"/> 0667	
PHYSICAL THERAPY	<input type="checkbox"/> 0208 <input type="checkbox"/> 0667	
SPEECH THERAPY	<input type="checkbox"/> 0208 <input type="checkbox"/> 0667	
ADULT COMPANION	<input type="checkbox"/> 0208	
TRANSPORTATION	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037 <input type="checkbox"/> 0667	
RESPIRE	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037 <input type="checkbox"/> 0667	
ADAPTIVE EQUIPMENT/ ENVIRONMENTAL MODIFICATIONS	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037 <input type="checkbox"/> 0667	
INDIVIDUAL GOODS AND SERVICES	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037 <input type="checkbox"/> 0667	
PRIVATE DUTY NURSING	<input type="checkbox"/> 0208	
HOMEMAKER	<input type="checkbox"/> 0208	
PERSONAL CARE	<input type="checkbox"/> 0208	
RESIDENTIAL HABILITATION	<input type="checkbox"/> 0208	
INDIVIDUAL EMPLOYMENT SUPPORT	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037	
FOLLOW ALONG SUPPORT	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037	
CO-WORKER SUPPORT	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037	
SMALL GROUP EMPLOYMENT	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037	

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JOB DISCOVERY/JOB PREP	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037	
RETIREMENT SERVICES	<input type="checkbox"/> 0208	
DAY SUPPORTS AND ACTIVITIES	<input type="checkbox"/> 0208	
SUPPORTS BROKERAGE	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037	
PERSONAL SUPPORTS	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037	
PSYCHOLOGICAL SERVICES	<input type="checkbox"/> 0208	
ADULT FOSTER SUPPORT	<input type="checkbox"/> 0208	
RESIDENTIAL TRAINING SUPPORT	<input type="checkbox"/> 0208	
ASSISTED LIVING	<input type="checkbox"/> 0208	
BEHAVIORAL SUPPORT SERVICES	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037	
CARE GIVER TRAINING AND SUPPORT	<input type="checkbox"/> 0208	
COMMUNITY TRANSITION SERVICES	<input type="checkbox"/> 0208	
NUTRITIONIST	<input type="checkbox"/> 0208	
MEALS	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037	
LIVE-IN CAREGIVER	<input type="checkbox"/> 0208	
REMOTE MONITORING	<input type="checkbox"/> 0208	
REMOTE MONITORING EQUIPMENT *must lease equipment	<input type="checkbox"/> 0208	
PERS	<input type="checkbox"/> 0208 <input type="checkbox"/> 1037	

Required Attachments

1. A brief narrative of proposed services and service settings (five pages or less)
2. An organization chart and narrative describing how the delivery of services is/will be organized, and supervised, including a description of the role, function and span of control of administrative components, and the location of each full time equivalent employee in the organization's structure.

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3. A delineation of the services to be provided directly by the primary corporation's employees and those to be provided by other service entities through contractual and other arrangements.
4. Copies of the contracts and other agreements made with other entities, ensuring the ready availability of the services at the required levels.
- For REMOTE MONITORING EQUIPMENT, a copy of the signed lease agreement must be submitted to DDP prior to invoicing for the service.
5. For persons or entities contracted with for the provision of any services, copies of their independent contractor certification from the Montana Department of Labor.
6. Process/procedures to ensure that individual's served have a safe and healthy environment.
7. Process to identify each individual's needs, necessary supports, and resources available.
8. Procedure to implement and provide necessary supervision, supports, education, and training needs identified in the individual plans of care.
9. Describe in detail the duties, qualifications, and levels of pay for all persons employed.
10. The following organization plan information is required:
- a. for each staff position classification in the organization chart, provide a brief description of general job duties and the entry level salary and benefits package for the position;
 - b. the organization's plan for obtaining a criminal background check through the Montana Department of Justice for each employee hired;
 - c. the organization's plan for providing, and the content of, pre-service training provided to new employees;
 - d. the organization's plan for providing, and the content of, ongoing in-service training for all employees;
 - e. the number of staff to be dedicated to meeting the health and safety of the consumers to be served and/or caseload sizes for each service included in the application; and,
 - f. the organization's plan for ensuring that all staff are competent to meet the needs of the consumers they serve.

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- 11. Procedures for each person served which provide for emergency backup and support to deal with problems that arise when services are interrupted, delayed, or consumer needs significantly change.
- 12. Procedures to ensure services delivered or coordinated by you will meet the required qualified provider standards.
- 13. Attach documentation verifying the availability and location of applicable Medicaid-reimbursable medical providers for State Plan services if these services are not directly provided by the applicant. State Plan pharmacy, personal care, physician, nursing, dental, hearing, vision and extended waiver professional therapy services must be available upon request to persons served in DD Waivers.

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Letters of Support

A minimum of two letters of support are required and must be addressed and mailed to the applicant. These must be from persons with knowledge of the applicant's work experience, professional ethics, and quality of services provided in the field of human services. Attach copies of letters of support. These references and other persons with appropriate knowledge may be contacted by DDP as part of a reference check.

Name: _____ **Phone:** _____

Address: _____

Name: _____ **Phone:** _____

Address: _____

Sign Off

READ CAREFULLY: By signing this application, I certify that:

- The information contained in this application is correct to the best of my knowledge and I understand that any misstatement or omission of information may result in termination of the contract between the Developmental Disabilities Program and the service provider agency.
- I authorize the references listed above to provide the DDP any and all information concerning my work experience, professional ethics and quality of services I have provided or been involved in providing in the field of human services and I release those references from all liability for any damage that may result from furnishing such information to the Department of Public Health and Human Services Developmental Disabilities Program. .
- I understand that as a qualified provider of services to persons with developmental disabilities which are funded by the Developmental Disabilities Program, I am required to comply with all state and federal laws, rules and policies governing provision of those services and that failure to do so may result in termination of the contract between the Developmental Disabilities Program and the service provider agency or other civil or criminal penalties. A failure to do so may also result in the requirement to repay funds with substantial interest and in some cases penalties.

Applicant Name (printed) _____

Signature: _____ **Date:** _____

Note: The DDP may contact any or all references for additional information.

An assigned representative of the DDP will review the application packet within thirty (30) days of receipt of the packet, and will contact the applicant regarding follow up activities.

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Please call the DDP at (406) 444-2995 with any questions, in order to be directed to the appropriate Regional Manager.