Department of Health
Developmental Disabilities Supports Division

Medically Fragile (MF) Waiver Provider Information Sheet

(*Form must be filled out completely*)
PLEASE PRINT CLEARLY

Date: _____ **New Applicant** _____ **Renewing Applicant** _____

State Bureau of Revenue CRS# _____ **Medicaid Billing #**_____

Business Name (dba) _____

Contact Person _____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

Physical Address _____

City _____ **State** _____ **Zip Code** _____

Phone # _____ **Fax #** _____ **Cell #** _____

E-mail Address _____ **Toll Free #** _____

Please answer the following questions regarding your organization:
1.) Does any other organization (including those who currently or previously provided service under the DDSD Medicaid Waiver program) control or influence your agency? Yes _____ (*or*) **No** _____
(If "YES" please provide name(s) and contact information below, if necessary, submit a separate sheet)

Contact _____ **Phone #** _____ **Email** _____

2.) Does your agency control or influence any other organization (including those who currently or previously provided service under the DDSD Medicaid Waiver program)? Yes _____ (*or*) **No** _____
(If "YES" please provide name(s) and contact information below, if necessary, submit a separate sheet)

Contact _____ **Phone #** _____ **Email** _____

Please fill out and sign this sheet.

1. Name and address of each person with an ownership or controlling interest in the entity.

Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**

2. Name of any person, agent, managing employee or any other person who has ownership or controlling interest in the entity who has been convicted of a criminal offense or assessed a civil monetary penalty related to that person's involvement in any program under Medicaid, Medicare, other federal program, or other state Medicaid programs.

Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**

Signature of Authorized Representative:	**Title:**

SERVICE AND COUNTY REQUEST FORM
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
MEDICALLY FRAGILE (MF) WAIVER

PROVIDER NAME:	DATE:

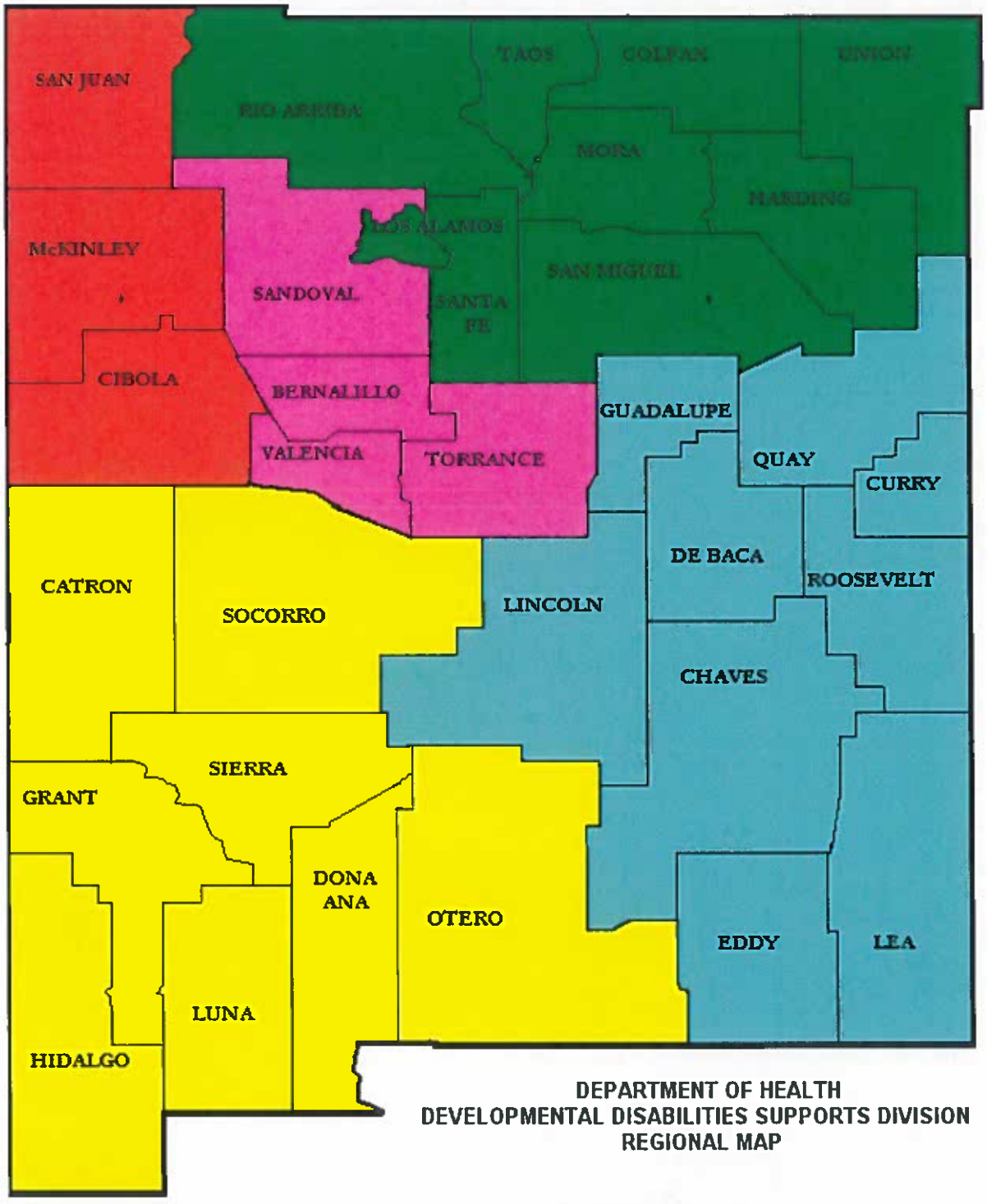
CHECK **THE SERVICE(S) YOU ARE APPLYING TO PROVIDE**

- ☐ BEHAVIOR SUPPORT CONSULTATION
- ☐ CASE MANAGEMENT *Must choose entire region for CM service.
- ☐ CUSTOMIZED COMMUNITY GROUP SUPPORTS
- ☐ ENVIRONMENTAL MODIFICATION
- ☐ HOME HEALTH AIDE
- ☐ IN-HOME RESPITE
- ☐ INDIVIDUAL DIRECTED GOOD AND SERVICES
- ☐ MASSAGE THERAPY
- ☐ NUTRITIONAL COUNSELING
- ☐ OCCUPATIONAL THERAPY
- ☐ PHYSICAL THERAPY
- ☐ PRIVATE DUTY NURSING
- ☐ SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES
- ☐ SPECIALIZED RESPITE HOME
- ☐ SPEECH THERAPY
- ☐ VEHICLE MODIFICATION

CIRCLE **THE COUNTIES YOU ARE APPLYING TO PROVIDE SERVICES IN.**

*If you are providing multiple services in multiple counties, please submit a separate form for each county.

METRO	BERNALILLO	SANDOVAL	TORRANCE	VALENCIA		
NORTHEAST	COLFAX	HARDING	LOS ALAMOS	MORA	RIO ARRIBA	SAN MIGUEL
	SANTA FE	TAOS	UNION			
NORTHWEST	CIBOLA	MCKINLEY	SAN JUAN			
SOUTHEAST	CHAVES	CURRY	DE BACA	EDDY	GUADALUPE	LEA
	LINCOLN	QUAY	ROOSEVELT			
SOUTHWEST	CATRON	DONA ANA	GRANT	HIDALGO	LUNA	OTERO
	SIERRA	SOCORRO				



DEPARTMENT OF HEALTH
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
REGIONAL MAP

NORTHWEST REGION

NORTHEAST REGION

SOUTHWEST REGION

SOUTHEAST REGION

METRO REGION

Department of Health
Developmental Disabilities Supports Division
Statement of Assurances

Failure to comply with this Statement of Assurances may result in DDSD sanctions, up to and including a reduction in the term and/or termination of the Provider Agreement.

This form must be completed and signed by the applicant. If any portion does not apply to your agency, please mark it as non-applicable.

	INITIAL	DATE	N/A
Any individual who is an employee or subcontractor of an entity that is compensated for providing waiver services to an individual, must not provide services as guardian or Power of Attorney for that individual, except when related by affinity or consanguinity.			
Similarity, a person who is an owner, operator or employee of a provider agency, or a subcontractor that is compensated to provide waiver services to a given individual must not be designated under a Power of Attorney to make healthcare decisions for that same individual, unless the owner, operator or employee is related to the individual by blood, marriage or adoption. *See* NMSA 1978, § 24-7A-2(B) (Uniform Healthcare Decisions Act).			
A case management or Community Supports Coordinator provider agency may not be a provider agency for any other waiver service. A case management or Community Supports Consultant provider agency may not provide guardianship services to an individual receiving case management or Community Supports Coordinator services from that same agency. Case managers or Community Supports Coordinators are not permitted to serve on the board of a provider agency.			
Provider agencies will follow the Center for Medicare and Medicaid Services (CMS) Final Rule requirements. https://www.medicaid.gov/medicaid/home-community-based-services/index.html			
Provider agencies will learn, and use designated electronic systems as required for documentation, reporting and billing (i.e., Therap components, Conduent online portals, other online portals, etc.)			
Provision of data that validates service provision as requested in by the State for audits, validation of rates of reimbursement during periodic rate reviews/rate studies or other quality assurance activities.			
Provider agencies will document provision of services according to Medicaid billing requirements.			

Provider agencies will provide Adult Nursing Services and comply with the DD Waiver Service Standard requirements for this service, as applicable.			
Provider agencies will maintain all individual's files for up to six (6) years after the termination, Expiration of Provider Agreement or when an individual chooses to transition to another agency. Jackson Class Member files will be maintained permanently.			
Provider agencies must submit liability and bond insurance to the Provider Enrollment Unit (PEU) annually.			
Provider agencies will submit a current list of each Board Member's name, home address, phone number and email address to the PEU annually, if applicable.			
Provider agencies must notify the PEU if there is a change in licensee or subcontractor status with the provider agency.			
MF Waiver providers will maintain current certificates for licensed health facilities.			

IMPORTANT:

Failure to comply with the DDSD Statement of Assurances may result in DDSD sanctions, up to and including a reduction in the term and/or termination of the Provider Agreement.

Provider Signature and Title **Date**

Department of Health
Developmental Disabilities Supports Division
Renewing Provider Agency Status Sheet

1. What was the date of your agency's last Quality Management Bureau (QMB) audit? (Applicable services only) _____

2. What was your agency's last QMB audit rating and what were the major issues?

3. If a Plan of Correction was issued, what is the status of the plan? If not closed, please explain why.

4. Has your agency been referred to the Internal Review Committee (IRC)? Yes or No
If so, when, and why?

5. Has your agency ever been placed on a State Imposed Moratorium? Yes or No
If so, when, and why?

6. Has the Regional Office placed your agency on a Performance Improvement Plan? Yes or No If so, when, and why?

7. How many individuals does your agency serve in each service, in each region you are approved to provide services in? (You may attach a separate sheet if needed)

PEU Provider Application Checklist

Provider Name: _____ Date Received: _____

Reviewer: _____ Date Reviewed: _____

New: _____ Renewing: _____

REQUIRED FORMS

____ DDSD Provider Information Sheet DD ____ MF ____SW____

____ Service and County Request Form DD ____ MF ____SW____

____ Provider Agency Status Sheet (Renewing providers only)

____ Statement of Assurances Form

____ Proof of registration with the New Mexico Department of Taxation and Revenue (CRS#)

____ Articles of Incorporation / Board Members ____

____ Proof of Professional Liability Insurance: Naming Department of Health ____
(New providers within 30 days of approval)

____ Proof of Surety or Fidelity Bond: Naming Department of Health ____
(New providers within 30 days of approval)

ACCREDITATION

____ Accreditation Plan ____ Survey Date ____ Current Providers **Expires:** _____

____ Exemption Requested _____ Exempt ____

(AT/BSC/CM/CS/EM/ILT/MT/NC/NMT/OT/PRS/PST/PT/RN/SLP/SSE/VMS)

FINANCIAL

Business Plan (New provider) ____ Operating Budget (Renewing provider) ____

Annual Tax Return ____ Profit and Loss Statement ____ Financial Audit prepared by Accountant ____

Other: _____

QMB Survey, if applicable ____

PEU Provider Application Checklist

PROGRAM PORTION(S)

Developmental Disabilities Waiver: ____

____ Mission statement

____ Organizational chart and brief position descriptions including management and supervisory positions.

____ Service Specific Questions

____ Agency Authoritative Documents per Service Type (Policies)

Medically Fragile Waiver: ____

___ Mission statement

___ Values statement

___ Organizational chart and brief position descriptions including management and supervisory positions.

____ Director's Resume

____ Agency Authoritative Documents per Service Type (Policies)

Supports Waiver: ____

____ Mission statement

____ Organizational chart and brief position descriptions including management and supervisory positions.

____ Director's Resume

____ Agency Authoritative Documents per Service Type (Policies)

PROFESSIONAL LICENSURE

____ Current Professional Licensure/Certification (BSC/CM/EM/MT/NC/OT/PT/RN/SLP)

____ Living Supports Providers must have NC and RN