



## AGENCY BASED COMMUNITY BENEFITS – ABCB PROVIDER APPLICATION PACKET CHECKLIST

Organization		Date	
Contact		Title	
Email Address		Phone No.	
<b>THE FOLLOWING FORMS, COPIES AND OTHER DOCUMENTS ARE SUBMITTED AS PART OF THE APPLICATION PROCESS TO BECOME AN APPROVED AGENCY BASED COMMUNITY BENEFIT PROVIDER</b>			
<b>Forms</b>			
<input type="checkbox"/>	ABCB Provider Application Packet Checklist - MAD 500A		
<input type="checkbox"/>	ABCB Scope of Work Service Summary Form - MAD 501A		
<input type="checkbox"/>	ABCB Statement of Financial Solvency - MAD 502		
<input type="checkbox"/>	ABCB Attestation Form - CMS Final Rule for HCBS - MAD 615		
<input type="checkbox"/>	ABCB Quality Assurance Form - MAD 741		
<input type="checkbox"/>	ABCB Program Assurances - MAD 899		
<input type="checkbox"/>	W-9		
<b>Copies of</b>			
<input type="checkbox"/>	Current Business License(s) - <b>City/Council Business License showing application address</b>		
<input type="checkbox"/>	Current Department of Health License - <b>Adult Day Health, Assisted Living, Home Health Aide</b>		
<input type="checkbox"/>	Current State Professional Licenses - <b>Environmental Modifications, Behavior Support Consultation, Private Duty Nursing, Nursing Respite, Occupational Therapy, Physical Therapy, Speech Therapy</b>		
<input type="checkbox"/>	IRS Letter - <b>Employer Identification Number verification</b>		
<input type="checkbox"/>	IRS 501(c)(3) letter - <b>If not-for-profit</b>		
<input type="checkbox"/>	NMTRD Registration Certificate - <b>New Mexico 11 digit Tax Identification Number</b>		
<input type="checkbox"/>	Professional Liability Insurance Certificate - <b>Current Certificate of Insurance is required</b>		
<input type="checkbox"/>	Workers Compensation Insurance Certificate - <b>Current Certificate of Insurance is required</b>		
<input type="checkbox"/>	Dishonesty/Surety Bond - <b>Emergency Response, Environmental Modifications applications only</b>		
<input type="checkbox"/>	Letter from bank indicating financial solvency/credit status, or Agency bank account statement with personal identifiers blacked out		
<input type="checkbox"/>	Articles of Incorporation - <b>if applicable</b>		



## PROVIDER APPLICATION PACKET CHECKLIST (continued)

<b>Organization Name:</b>					
<b>Copies of (continued)</b>					
<input type="checkbox"/>	List of Board members with addresses, terms of service, and positions on Board				
<input type="checkbox"/>	Verification of National Provider Identifier - <b>Adult Day Health, Assisted Living, Private Duty Nursing, Nursing Respite</b>				
<b>Information about Organization</b>					
<input type="checkbox"/>	Statement regarding Agency's mission and purpose				
<input type="checkbox"/>	Physical location, address and phone numbers for each service site or office				
<b>Written Description of Service Provision</b>					
<input type="checkbox"/>	Statement describing the agency's experience in providing the services for which the agency is applying, including a summary of the background and experience of staff members.				
<input type="checkbox"/>	Description of the agency's approach to delivering the specific Agency Based Community Benefit services requested, including staff orientation and training requirements.				
<input type="checkbox"/>	Description of staff qualifications, including copies of individual professional licenses, as appropriate.				
<input type="checkbox"/>	Description of methods used to communicate with staff, regarding the needs and service goals of the individual to be served.				
<input type="checkbox"/>	Copies of emergency and on call procedures				
Authorized Signature		Title		Date	