

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

This application is for qualification as a new provider to deliver services for the Developmental Disabilities Program (DDP). Qualified providers may deliver, or may coordinate the delivery of, those Department-approved services meeting the standards outlined as defined in the waivers, subject to the financial limitations of the individual cost plans.

Applying to become a new Qualified Provider

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 [WAIVER DEFINITION/QP STANDARDS](#) [RATES](#)

Supports for Community Working/Living 1037 [WAIVER DEFINITION/QP STANDARDS](#) [RATES](#)

Children's Autism Waiver 0667 [WAIVER DEFINITION/QP STANDARDS](#) [RATES](#)

| 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 | |
| SE - INDIVIDUAL EMPLOYMENT SUPPORT | <input type="checkbox"/> 0208 <input type="checkbox"/> 1037 | |
| SE - FOLLOW ALONG SUPPORT | <input type="checkbox"/> 0208 <input type="checkbox"/> 1037 | |
| SE - CO-WORKER SUPPORT | <input type="checkbox"/> 0208 <input type="checkbox"/> 1037 | |
| SE - 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 | |

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Required Attachments

- 1. A brief narrative of proposed services and service settings (five pages or less)
Include:
 - (a) Business mission statement
 - (b) Date the business began
 - (c) Summary of management's future plans
 - (d) Market analysis (if one has been completed)
 - (e) List the primary factors believed to make the business a success

- 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.

- 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. (If applicable) For established businesses – provide historical financial data related to the company's performance. Include: Company's income statements, balance sheets, and cash flow statements for each of the years in business (up to 3 years) and a summary of the company's growth.

- 5. 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.

- 6. For persons or entities contracted with for the provision of any services, copies of their independent contractor certification from the Montana Department of Labor.

- 7. Process/procedures to ensure that individual's served have a safe and healthy environment.

- 8. Procedure to identify each individual's needs, necessary supports, and resources available.

- 9. Process/procedures to learn if the needs of clients/families are being met.

- 10. Procedure to implement and provide necessary supervision, supports, education, and training needs identified in the individual plans of care.

- 11. Describe in detail the duties, qualifications, and levels of pay for all persons employed.

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12. 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.
13. 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.
14. Procedures to ensure services delivered or coordinated by you will meet the required qualified provider standards.
15. 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.
16. Describe the financial resources and capabilities of the organization.

17. The following financial information is required:

- a. Submit a proposed budget that reflects the types of services and the numbers of consumers in those services that the entity is anticipating serving;
 - i. A proposed budget must reflect three full years of operation (i.e. annualized). The budget must be all inclusive (all sources of funds and budgeted

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expenditures must be included). Budgeted expenditures must include both direct and indirect costs.

All businesses, whether startup or established, need to provide prospective financial data. The State of Montana wants to see what the owner expects the company to be able to do within the next three years. Each year's documents should include forecasted income statements, balance sheets, and cash flow statements. The applicant must provide an explanation of the methods and assumptions employed in estimating costs.

ii. Include a short analysis of the company's financial information.

NOTE: Providers receiving federal funds through the Developmental Disabilities Program are subject to financial reviews and audits conducted by audit staff from the State of Montana. Financial reviews and audits are conducted for purposes of assuring conformance with applicable state and federal fiscal and other authorities governing the expenditure of monies being expended through the contract and to assure that consumers are receiving services in accordance with the individual cost plans. In addition, financial reviews and audits serve to provide information necessary for the development of further prospective adjustments to reimbursement rates. Federal cost principles and expenditure accountability provisions in state rules and contracts are used to determine if costs are reasonable or allowable.

b. The following financial information is required for all:

i. A description of the financial management plan, accounting practices and billing practices. Include:

- (1) Description of the accounting and financial education and experience of the person(s) responsible for this function;
- (2) Description of the computerized accounting software system (ex. Quicken, QuickBooks, Peachtree, etc.) being used and the training and experience of the accounting staff in using that system;
- (3) Method used to allocate indirect costs. Is it applied consistently?
- (4) Are the accounting records reviewed by a Certified Public Accountant?

ii. Evidence that the applicant has, or can secure, sufficient working capital to maintain a positive cash flow including startup and initial funding requirements such as:

- (1) Ability/plan to fund initial cost plans when the initial billing revenue lags behind costs by at least 60 days;
- (2) Ability/plan to fund cost plans in a worst case scenario where revenue might lag behind costs by 120 days or more.

iii. The estimated total amount of capital expenditures to be financed, including as a separate item if needed, an estimate of the cost for the development and construction of facilities;

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- iv. A written commitment from a lending agency to provide the necessary capital financing or, if no agreement exists, an indication in writing from a lending agency that a strong likelihood of financing exists;
- v. A description of the general terms of any existing or proposed capital financing arrangement; and
- vi. The name, address, phone number, and e-mail of the financial officer or other responsible fiscal person designated by the applicant organization.

18. The applicant or renewing provider must:

- a. verify that the business has computer equipment that has high speed internet access and meets system requirements to ensure the capability to invoice using the DDP AWACS web-based billing system and for applications necessary to conduct business, including but not limited to WebEx training, College of Direct Support, Therap, the ICP system, and email.
- b. verify that all facilities in which services are provided meet all applicable licensure and certification requirements and health and safety codes;
- c. verify the adoption and implementation of policies and procedures to ensure a safe and healthy service environment for all consumers served;
- d. verify the adoption and implementation of policies and procedures to ensure health monitoring occurs and necessary medical assistance is provided or sought when needed;
- e. assure the delivery of the specific services funded in the Individual Cost Plan (ICP) are provided;
- f. verify the adoption and implementation of policies and procedures to assist consumers and staff in emergencies such as medical problems, behavior intervention, staff shortages, natural disasters, etc;
- g. assure the active participation of appropriate provider staff in the individual planning process when asked by the service recipient;
- h. verify the adoption and implementation of policies to assure suspected abuse, neglect, or exploitation of a consumer is reported to Adult Protective Services (APS) or Child and Services Division and the appropriate DDP Regional Office; and
- i. verify the adoption and implementation of policies to assure compliance with the Developmental Disabilities Program's Incident Management System rules and policies.

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j. verify that human resource policies include but are not limited to:

- i. Sick and annual leave
- ii. Pay – wage and hour
- iii. Discipline
- iv. Records Management
- v. Standards of conduct/ethics model (dress code, phone, vehicle use)
- vi. Grievance
- vii. Holidays
- viii. Performance management and evaluation
- ix. Probation
- x. Recruitment

19. Approved [Montana Medicaid Provider Enrollment Form](#).

20. [National Provider Identifier \(NPI\) Number](#).

21. Montana Department of Justice background check report for named applicant as well as List of Excluded Individuals and Entities (LEIE) and Medicare Exclusion Database (MED) checks.

22. For a non-profit (501 C-3 status) corporation, a list of the board members along with current addresses of the board of directors for the corporation, including a description of community involvements and any experiences or skills for overseeing the management of the organization. The board of directors for a nonprofit provider corporation must have one board member who is a consumer and one board member who is a consumer's family member.

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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.

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