

## **Organized Health Care Delivery System (OHCDS) Provider Enrollment Form**

By submitting this enrollment form

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**(Agency Name)**

seeks designation from the Office of Long-Term Living (OLTL) to be an Organized Health Care Delivery System (OHCDS). As an OHCDS, the agency will have authorization to subcontract with and pay qualified providers for certain services provided under OLTL waiver programs. By submitting this form, the agency agrees that:

1. The agency shall comply with all applicable state and federal statutes and regulations, and policies and announcements that pertain to participation in the Pennsylvania Medical Assistance Program, including the OLTL waivers.
2. The agency shall accept the waiver payment as payment in full for the service rendered and shall not seek any additional payment from a waiver participant under any circumstances.
3. The agency shall be responsible for the accuracy of all claims submitted under the agency's number, whether submitted by the agency or on the agency's behalf.
4. The agency shall not bill or receive payment for services that are not authorized in the Individual Service Plan (ISP).
5. The agency acknowledges that the submission of false or fraudulent claims could result in criminal prosecution and civil and administrative sanctions, including exclusion from participation in Medicare, the Pennsylvania Medical Assistance Program, other State Medicaid programs, and all other federal and state health care programs.
6. The agency shall comply with the disclosure requirements specified in federal regulations at 42 CFR Chapter 455, Subpart B (relating to disclosure of information by providers and fiscal agents).
7. The agency shall submit claims for waiver services in accordance with instructions issued by the Department.
8. The agency shall comply with all federal audit requirements, including the Single Audit Act, 31 U.S.C. §§ 7501-7507; the revised Office of Management and Budget (OMB) Circular A-133, Audits of States, Local Government, and Non-Profit Organizations; 45 CFR § 74.26 (relating to non-federal audits); and any other applicable statutes or regulation.
9. If the agency is subcontracting or paying the cost of the service provided by a provider or vendor under the waiver, the payment made by the agency may not exceed the cost charged by the vendor.

## OHCDs Provider Enrollment Form

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Agency Name

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MPI # (PROMISe™)

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Four Digit Service Location (PROMISe™)

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Service Location Address

**Please note:** One Provider Enrollment Information Form must be completed for **each** service location. This ensures that your agency's information is processed efficiently and accurately.

Under an OHCDs agreement, the Service Coordination agency should be verifying that providers rendering the service meet the waiver qualifications for services identified and have the applicable licenses as indicated in parenthesis below. Please identify below which of the following OHCDs services you will coordinate and be reimbursed for:

- Assistive Technology (*Drug and Device Certification from the Dept. of Health*)
- Community Transition Services (*License not required*)
- Home Adaptations (*Contractor's license if required by trade*)
- Home Delivered Meals (*Certification from the Dept. of Agriculture*)
- Non-Medical Transportation (*Public Utilities Commission license required*)
- Personal Emergency Response System (*License not required*)
- Vehicle Modifications (*Quality Assurance Program Accreditation by the National Mobility Equipment Dealers Association*)

**Selection of OHCDs waiver services does not indicate final approval. Services should not be provided until your agency is approved and the participant's individual service plan has been updated to reflect your agency as the approved service provider.**

I certify that the information provided on this Enrollment Information Form is true to the best of my knowledge.

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Signature of Authorized Representative

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Title

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Print Name

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Date