

Home and Community Based Waiver Services Provider Enrollment Information Form

STEP 1: Choose the Waiver/Program(s) that you are enrolling for.

- Aging
 Attendant Care/ACT 150
 COMMCARE
 Independence
 OBRA

STEP 2: Choose the service(s) you are enrolling for.

Does your agency provide complete care management and coordination for consumers? YES NO

If yes, please select the service(s) that you want to provide below:

- Service Coordination
 Transition Service Coordination (Nursing Home Transition Partners only)

If this option is selected, no other service on this form can be chosen.

Do you have a Home Care Agency license from the Dept. of Health? YES NO

If yes, please select the service(s) that you want to provide below:

- Personal Assistant Services (PAS)
 Personal Assistant Services (PAS) – Clustered Shared Living Arrangement (CSLA)
 Respite

Do you have a Home Health Agency license from the Dept. of Health? YES NO

If enrolling as an individual ONLY, do you have a license from the Department of State for an individual specialty?

YES NO

If yes, please select the service(s) that you want to provide below:

- | | |
|---|--|
| <input type="checkbox"/> Home Health Aide (<i>Aging Waiver only</i>) | <input type="checkbox"/> Home Health-Nursing (RN) |
| <input type="checkbox"/> Home Health-Nursing (LPN) | <input type="checkbox"/> Home Health-Occupational Therapy |
| <input type="checkbox"/> Home Health-Occupational Therapy-Assistant | <input type="checkbox"/> Home Health-Physical Therapy |
| <input type="checkbox"/> Home Health-Physical Therapy-Assistant | <input type="checkbox"/> Home Health-Speech & Language Therapy |
| <input type="checkbox"/> Behavioral Therapy | <input type="checkbox"/> Cognitive Therapy |
| <input type="checkbox"/> Counseling Services | <input type="checkbox"/> Nutritional Counseling |
| <input type="checkbox"/> Personal Assistant Services (PAS) | <input type="checkbox"/> Respite |
| <input type="checkbox"/> Personal Assistant Services (PAS) – Clustered Shared Living Arrangement (CSLA) | |

Do you have an Adult Day Care License from Human Services or the Dept. of Aging? YES NO

If yes, please select the service(s) that you want to provide below:

- Adult Daily Living
 Adult Daily Living Services Half Day
 Adult Daily Living Enhanced (*must have the additional Enhanced agreement*)
 Adult Daily Living Enhanced Half Day (*must have the additional Enhanced agreement*)

Please note that a provider may only choose Adult Daily Living or Adult Daily Living Enhanced – not both.

Does your agency specialize in services that assist consumers with obtaining new skills in order to be a part of their community? YES NO

If yes, please select the services that you want to provide below:

- Prevocational Services (*2390 Vocational Facility License*)
 Supported Employment
 Community Integration

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Does your agency specialize in a vendor service? YES NO

If yes, please select the service(s) that you want to provide below:

- Assistive Technology (*Drug and Device Certification from the Dept. of Health*)
- Community Transition Services
- Home Adaptations (*Contractor's license if required by trade*)
- Home Delivered Meals (*Certification from the Dept. of Agriculture*)
- Non-Medical, Non-Emergency Transportation (*Public Utilities Commission license required*)
- Personal Emergency Response System (PERS) Installation and Maintenance
- Specialized Medical Equipment and Supplies (*Drug and Device Certification from the Dept. of Health*)
- Telecare Services (*Aging Waiver Only*) (*Home Health Agency License or Drug and Device Certification from Dept. of Health*)
- Vehicle Modifications (*Quality Assurance Program Accreditation by the National Mobility Equipment Dealers Association*)

Has your agency achieved CARF Brain Injury Home and Community Services accreditation? YES NO

If yes, please select the service(s) that you want to provide below:

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Residential Habilitation in a 1-3 group setting <ul style="list-style-type: none"> <input type="checkbox"/> Res. Habilitation Supplemental for 1:1 <input type="checkbox"/> Res. Habilitation Supplemental for 2:1 <input type="checkbox"/> Structured Day Habilitation-Group <ul style="list-style-type: none"> <input type="checkbox"/> Structured Day Supplemental for 1:1 <input type="checkbox"/> Structured Day Supplemental for 2:1 | <ul style="list-style-type: none"> <input type="checkbox"/> Residential Habilitation in a 4-8 group setting <ul style="list-style-type: none"> <input type="checkbox"/> Res. Habilitation Supplemental for 1:1 <input type="checkbox"/> Res. Habilitation Supplemental for 2:1
(Must be licensed as a Personal Care Home) |
|--|---|

These services are available in the COMMCARE and OBRA waivers only
Supplemental Services cannot be selected without a corresponding group setting service

STEP 3: Choose the counties your agency is willing and able to provide services in.

Region 1

- All Region 1 Counties
- Allegheny
- Armstrong
- Beaver
- Fayette
- Greene
- Washington
- Westmoreland

Region 2

- All Region 2 Counties
- Butler
- Cameron
- Clarion
- Clearfield
- Crawford
- Elk
- Erie
- Forest
- Jefferson
- Lawrence
- McKean
- Mercer
- Potter
- Venango
- Warren

Region 3

- All Region 3 Counties
- Bedford
- Blair
- Cambria
- Indiana
- Somerset

Region 4

- All Region 4 Counties
- Centre
- Clinton
- Columbia
- Lycoming
- Mifflin
- Montour
- Northumberland
- Snyder
- Tioga
- Union

Region 5

- All Region 5 Counties
- Adams
- Cumberland
- Dauphin
- Franklin
- Fulton
- Huntingdon
- Juniata
- Lancaster
- Lebanon
- Perry
- York

Region 6

- All Region 6 Counties
- Bradford
- Lackawanna
- Luzerne
- Monroe
- Pike
- Sullivan
- Susquehanna
- Wayne
- Wyoming

Region 7

- All Region 7 Counties
- Berks
- Carbon
- Lehigh
- Northampton
- Schuylkill

Region 8

- All Region 8 Counties
- Bucks
- Chester
- Delaware
- Montgomery

Region 9

- Philadelphia

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STEP 4: Please answer all of the following questions.

For 1915(c) Home and Community-Based waivers, settings that are not home and community based are defined at Federal Regulation 42 CFR 441.301(c)(5).

Does your agency provide services in any of the following settings?

- | | | |
|---|------------------------------|-----------------------------|
| 1. <i>Nursing Facility</i> | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. <i>Institution for Mental Diseases</i> | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 3. <i>Public or Private ICF/ID</i> | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 4. <i>Hospital</i> | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

For 1915(c) Home and Community-Based waivers, settings that are presumed to have the qualities of an institution are defined at Federal Regulation 42 CFR 441.301(c)(5)(v).

Does your agency provide services in a publicly or privately operated facility that provides inpatient institutional treatment?

YES NO

Does your agency provide services in a building on the grounds of, or immediately adjacent to, a public institution (A public institution is an inpatient facility that is financed and operated by a county, state, municipality, or other unit of government. A privately owned nursing facility is not a public institution.)

YES NO

Does your agency provide services in any of the following settings?

- | | | |
|--|------------------------------|-----------------------------|
| 1. <i>Farmstead or disability-specific farm community</i> | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. <i>Gated/secured community for people with disabilities</i> | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 3. <i>Residential school</i> | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

Do you own, rent/lease, or operate a residential setting (i.e. licensed or unlicensed) at this location where services are provided?

YES NO

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STEP 5: *Choose an effective date for the services to begin and sign below. Services cannot be backdated.*

Requested effective date: _____

Signature of Authorized Representative

Title

Print Name

Date

Agency Name

MPI # (PROMISe™)

Four Digit Service Location (PROMISe™)

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.

Selection of waiver services does not indicate final approval. Services should not be provided until your agency is approved and the participant's service plan has been updated to reflect your agency as the approved service provider. Qualifications for each service will be reviewed and approved at the time of enrollment. Please be sure to include a copy of all valid licenses.

Staff qualifications needed to provide that service can be found in each individual waiver.

<http://www.dhs.state.pa.us/foradults/healthcaremedicalassistance/supportserviceswaivers/index.htm>