

**INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISE™
PROVIDER ENROLLMENT GROUP APPLICATION**

Applications must be typed or completed in black ink, or they will not be accepted.

Applications will be scanned - please do NOT staple.

Note: Out-of-State providers must submit proof of participation in your State's Medicaid Program.

1. Enter the complete name of the group.
- 2a. Check the appropriate boxes for the action(s) you request.
- 2b. If you are reactivating a provider number, indicate the PROMISE™ 13 digit provider number you wish to have reactivated and complete the application as an initial enrollment.
- 2c. If this is a name change, indicate the old name and the new name. **To verify your updated name, a copy of a document generated by the Federal IRS listing your group name and FEIN must accompany your application.**
- 2d. If this is a change of ownership with no change in the IRS number, complete the "Ownership or Control Interest" sheet.
3. Enter your National Provider Identifier (NPI) Number and taxonomy(s). If you have more than 4 taxonomy codes, please attach an additional sheet noting the additional codes. **Include a legible copy of the NPPES Confirmation letter that shows the NPI Number and Taxonomy(s) assigned to the healthcare provider applying for enrollment. Refer to:**
<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/nationalprovideridentifiernpiinformation>
4. Enter the requested effective date for your action request.
5. Enter your provider type number and description (e.g., provider type 31, Physician).
6. Enter your specialty name and code number. **See the requirements for your provider type.**
7. Enter your sub-specialty name(s) and code number(s), if applicable. **See the requirements for your provider type.**
8. Enter your Tax Identification Number (TIN). **A copy of the TIN label or document generated by the Federal IRS containing your IRS number must accompany this application. A W-9 form will not be accepted.**
9. Enter your legal name as it is filed with the IRS and as it appears on IRS generated documentation.
- 10a. Indicate whether or not you participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs).
- 10b. Enter the names of any Pennsylvania Medicaid Managed Care Organizations with which you participate.
- 11a. Indicate whether the provider operates under a fictitious business/doing-business as (d/b/a) name.
- 11b. If applicable, enter the statement/permit number and the name. Attach a legible copy of the recorded/stamped fictitious business name statement/permit.
- 12a. Enter your IRS address. This address is where your 1099 tax documents will be sent.
- 12b-f. Enter the contact information for the IRS address.

13. Check the appropriate box for the business type of the group applying for enrollment. Check 1 box only. Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.
- 14a. Enter a valid service location address. **The address must be a physical location, not a post office box. The zip code must contain 9 digits and the phone number must be for the service location. See block #18 of the application to list an additional address(es) for Pay-to, Mail-to, and/or Home Office locations if different from the Service Location address entered in Block 15a.**
- NOTE* you can sign up for the **Electronic Funds Transfer Direct Deposit Option** by following the link below:
<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/electronicfundstransferdirectdepositinformation/index.htm>
- 14b-c. Answer question, if yes, enter you E-mail Address. If no, follow directions to access the bulletin information yourself. If you require paper bulletins or RA's please call the phone number listed.
- 14d. If you wish Medicare claims to crossover to this service location check this box. **Note: This crossover can be added to only one service location.**
- 14e-h. Enter contact information.
- 14i. Indicate whether you or your staff is able to communicate with patients in any language other than English.
- 14j. If applicable, list the additional languages in which you or your staff can communicate.
- 14k. Answer questions 1 through 4 pertaining to the Americans with Disabilities Act (ADA).
- 14l. Enter the appropriate Provider Eligibility Program(s) (PEP(s)). **See the PEP Descriptions and the requirements for your provider type (included with the instructions).**
15. Indicate whether you retain any managing employees or agents.
***IF "yes" complete Attachment I. Form found here:**
http://www.dpw.state.pa.us/cs/groups/webcontent/documents/form/p_011861.pdf
- 16a-e. Complete ALL confidential information questions, A through E.
If you answer "Yes" to any of the questions, provide a detailed explanation (on a separate piece of paper) and attach it to your application.
- 16f. Include responses to 16, 1 to 14, if you answered YES to any of the questions in 16A-E.
17. Sign the application and print your name, title, and date **(The signature should be that of the person authorized to represent the group applying for enrollment). Use black ink.**
18. Block #18 of the application may be used to add a mail-to, pay-to, and/or home office address to the **previously defined** service location address listed in 15a. **This sheet cannot be used to add a service location.**
***You must fill out a new application to add a service location.**
- 18a. Enter the corresponding mail-to, pay-to, and/or home office address for the service location.
- 18b. Indicate whether you are adding a mail-to, pay-to, and/or home office address.
- 18c. Enter the e-mail address of the contact person for this address.
- 18d-g. Enter the contact information for this address.

When completed, review the "Did You Remember..." Checklist included with the application. Then return your application and other documentation to the address listed on the requirements for your specific provider type. If no address is listed on the requirements for your specific provider type/specialty, please mail to:

DPW Enrollment Unit PO Box 8045 Harrisburg, PA 17105-8045

Provider Eligibility Program (PEP) Descriptions

This information applies to Question 14I of the Pennsylvania PROMISe™ Provider Enrollment Group Application.

A Provider Eligibility Program (PEP) code identifies a program for which a provider may apply. A provider must be approved in that program to be reimbursed for services to consumers of that program. Providers should use the following PEP codes when enrolling in PROMISe™ and should use the descriptions in this document to determine which PEP code to use when enrolling in PROMISe™.

Adult Autism Waiver— **Contact Number:** (866) 539-7689; Email: ra-odpautismwaiver@pa.gov ;

Website: <http://www.dpw.state.pa.us/foradults/autismservices/adultautismwaiver/index.htm>

The AAW is designed to help adults with an autism spectrum disorder participate in their communities in the way that they want to, based on their individual needs. It is a statewide home and community-based waiver. To become an AAW provider, contact the Bureau of Autism Services and an enrollment representative will reply by phone or by sending an electronic "Provider Packet." The packet includes necessary links, information and instructions on how to become an enrolled provider.

Aging Waiver – **Contact Number:** (717) 772-2570 or (800) 932-0939

Providers should enroll in the Aging Waiver if they would like to provide home- and community-based services to Nursing Facility Clinically Eligible (NFCE) individuals age 60 or over. Services provided in this PEP are personal care, respite, transportation, adult day care, durable medical equipment (DME) and supplies, environmental modifications, home health care, home delivered meals, personal emergency response services, counseling, and personal assistance services (attendant care).

AIDS Waiver - **Contact Number:** (717) 772-2570 or (800) 932-0939

Providers may enroll in the AIDS waiver to provide home- and community-based services to individuals 21 and older with AIDS or Symptomatic HIV Disease. Services provided are Home Health care, Homemaker, Nutritional Consultation and Supplements and Specialized Medical Equipment and Supplies. Providers in non-mandatory Managed Care Counties must be approved by the Waiver Enrollment Unit of the Bureau of Provider Support in the Office of Long Term Living. Providers in mandatory Managed Care Counties should apply to be a provider with the Managed Care entity in their area.

Attendant Care Waiver/ Act 150 Program - **Contact Number:** (717) 772-2570 or (800) 932-0939

A Home and community based program developed for mentally-alert Pennsylvanians with physical disabilities. Services provided through the Attendant Care Waiver include:

- Attendant Care (Agency and Consumer Model), such as:
 - Assisting a person to get in and out of bed, wheelchair and/or motor vehicles
 - Assisting a person to perform routine bodily functions
 - Assistance with cognitive tasks including managing finances, planning activities, and making decisions
 - Companion-type services, including assistance with transportation, letter writing, reading mail, and escort
 - Financial Management Services
 - Homemaker type services, such as shopping, laundry, cleaning, and seasonal chores
- Personal Emergency Response System (Installation and Maintenance)
- Service Coordination

Providers in mandatory Managed Care Counties should apply to be a provider with the Managed Care entity in their area.

BHHC – Contact Number: (800) 433-4459

Assignment of BH HC reflects an enrollment in PROMISe to serve in-plan supplemental HealthChoices clients. This PEP is not considered an entitlement for funding from any MHMR Program, nor a guarantee of a definitive number of referrals.

COMMERCARE Waiver - Contact Number: (717) 772-2570 or (800) 932-0939

Home and community based program developed for individuals who experience a medically determinable diagnosis of traumatic brain injury (TBI). Services provided through the COMMERCARE Waiver include:

- Accessibility Adaptations, Equipment, Tech & Med Supplies
- Community Integration
- Educational Services
- Financial Management Services
- Habilitation and Support
- Home Health (RN, LPN, Physical/Occupational/Speech Therapy)
- Personal Assistance Services
- Personal Emergency Response System (Installation and Maintenance)
- Prevocational Services
- Respite (Consumer or Agency Model)
- Service Coordination
- Structured Day Program
- Supported Employment
- Therapeutic & Counseling Services
- Transportation

Consolidated Waiver – (888) 565-9435

Home and Community-Based program developed for Pennsylvania residents age 3 and older with a medically determined diagnosis of mental retardation. The Consolidated Waiver is designed to provide services to eligible persons with mental retardation so that they can remain in the community

Fee-for-Service (FFS) - Contact Number: (800) 537-8862 – Option 1

A comprehensive set of Medical Assistance services which include reimbursement for direct inpatient and outpatient, physical health, and behavioral health services to consumers through components of the Medical Assistance Program. If you are trying to provide services under the Managed Care and/or FFS programs, you should select the FFS PEP.

If you are requesting enrollment to be a provider of a HealthChoices Supplemental Service(s) for Behavioral Health, contact the BH-MCO with which you will be doing business as this application is not applicable.

Healthy Beginnings Plus (HBP) - Contact Number: (717) 772-6127

Healthy Beginnings Plus (HBP) is Pennsylvania's effort to assist low-income pregnant women, who are eligible for Medical Assistance, to have a positive prenatal care experience. HBP expands the scope of maternity services that can be reimbursed by the Medical Assistance Program. Care coordination, early intervention, and continuity of care as well as medical/obstetric care are important features of the HBP program. Services covered by HBP include childbirth and parenting classes, nutritional and psychosocial counseling, smoking cessation counseling, home health services and other individualized client services. Please note: A separate HBP enrollment application must be completed to add this program to your eligibility.

Independence Waiver - Contact Number: (717) 772-2570 or (800) 932-0939

The Independence waiver provides services to persons with physical disabilities to allow them to live in the community and remain as independent as possible. Services provided through the Independence Waiver include:

- Accessibility Adaptations, Equipment, Tech & Med Supplies
- Adult Daily Living
- Community Integration
- Educational Services
- Financial Management Services
- Home Health (RN, LPN, Physical/Occupational/Speech Therapy)
- Personal Assistant Services
- Personal Emergency Response System (Installation and Maintenance)
- Respite Care
- Service Coordination
- Therapeutic & Counseling Services
- Transportation Services

Living Independently for Elders (LIFE) – Contact Number: (717) 772-2570 or (800) 932-0939

Providers should enroll as a provider under the Long Living Independently for Elders (LIFE) if they plan to provide long-term care services to Nursing Facility Clinically Eligible (NFCE) individuals age 55 or over. All providers in this PEP must be approved by the Division of LTC Client Services and have an existing agreement with the Department to provide services under the national Program of All-inclusive Care for the Elderly (PACE) model under either federal PACE provider Status or under Prepaid Health Plan Authority. The goal is to maintain individuals in the community, but services are also provided in institutional settings when appropriate. Providers manage and provide an all-inclusive package of services to enrolled recipients and are reimbursed a monthly capitation payment for services provided.

Mental Retardation Base Program (MR Base Program) - Contact Number: (888) 565-9435

The MR Base Program is a program that is designed for Pennsylvania residents of any age who have a medically determined diagnosis of mental retardation.

OBRA Waiver - Contact Number: (717) 772-2570 or (800) 932-0939

Services provided through the OBRA Waiver include:

- Accessibility Adaptations, Equipment, Tech & Med Supplies
- Adult Daily Living
- Community Integration
- Educational Services
- Financial Management Services
- Home Health (RN, LPN, Physical/Occupational/Speech Therapy)
- Personal Assistant Services
- Personal Emergency Response System (Installation and Maintenance)
- Prevocational Services
- Respite Care
- Service Coordination
- Supported Employment Services
- Therapeutic & Counseling Services
- Transportation Services

Person/family Directed Support Waiver (Per/Family Services) – Contact Number: (888) -565-9435

The Person/Family Directed Support Waiver is a Home and Community-Based waiver program that is designed for Pennsylvania residents age 3 and older with a medically determined diagnosis of Mental Retardation. This waiver is designed to prevent the institutionalization of individuals with mental retardation who do not require Office of Developmental Programs licensed community residential services and allows these individuals to remain in the community.

ATTENTION OMR PROVIDERS:

Fax completed application to ODP @ 717-783-5141 or mail to:

Office of Developmental Programs

Attn: ODP Provider MA Agreement

P.O. Box 2675, Room 413

Health and Welfare Building

Harrisburg, PA 17105-2675

PROMISe™ PROVIDER ENROLLMENT GROUP APPLICATION

1. Enter Complete Group Name:

2. Action Request: Check Boxes that Apply:

a. Initial Enrollment: Group

b. Check here if previously enrolled in Medical Assistance (MA).

Enter Provider Number (if known): _____ (13 digits)

(Complete the application as an initial enrollment.)

c. Name Change: (Name change only. Must match IRS generated documentation.)

Old Name: _____

New Name: _____

d. Change of Ownership:

No Change in IRS number (Complete the "Ownership or Control Interest" form.).

Change in IRS Number (Complete the application as an initial enrollment)

3. National Provider Identifier Number: _____ (10 digits)

Taxonomy(s): _____ (10 digits) _____ (10 digits)

Taxonomy(s): _____ (10 digits) _____ (10 digits)

4. Requested Effective Date:

yyyy / mm / dd – (2004/07/31)

____/____/____

5. Provider Type Number and Description:

Number: ____ (2 digits)

Description: _____

6. Specialty(s) and Code(s), if applicable:

Specialty: _____

Code Number: ____ (3 digits)

7. Sub-Specialty(s) and Code(s), if applicable:

Sub-Specialty(s): _____

Code Number(s): ____ / ____ (3 digits)\

8. Federal Tax ID Number:

_____ (9 digits)

***A copy of a document generated by the Federal IRS with your name and IRS number must accompany this application.**

9. Legal Name Shown on Attached Document:

10a. Do you intend to participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs)?

Yes No

10b. If so, list the MCO(s):

11a. Does the provider operate under a fictitious business/doing business as (d/b/a) name?

Yes No

11b. If yes, list the Statement/Permit number and the name:

Number: _____

Name: _____

***A legible copy of the recorded/stamped fictitious business name statement/permit is required for your application to be processed.**

12a. IRS Address: **Note:** This is the address where your 1099 tax document will be sent.

Street: _____ Room/Suite: _____

City: _____ State: _____ Zip: _____ - _____ (9 digits)

County: _____

12b. Contact Name/Title:

Name: _____

Title: _____

12c. Contact E-Mail Address:

12d. Contact Phone:

()

12e. Contact Toll-Free Phone:

()

12f. Contact Fax Number:

()

13. Business Type: (Check 1 Box Only)

Business Corporation, For Profit

Not For Profit

Sole Proprietorship

Estate/Trust

Partnership

Government Owned

Public Service Corporation

14a. Service Location Address: **(A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.)**

Street: _____ Room/Suite: _____

City: _____ State: _____ Zip: _____ - _____ (9 digits) County: _____

Business Phone:

() _____ - _____

Fax Number:

() _____ - _____

Is this address an active Rural Health Clinic or FQHC?

Yes

No

Check all applicable boxes. This service location is also a: Pay-to Mail-to Home Office

If Pay-to, Mail-to, and/or Home Office are different from above address, refer to block #18

If you wish to utilize the **Electronic Funds Transfer Direct Deposit Option** please follow link for further information:

<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/electronicfundstransferdirectdepositinformation/index.htm>

14b. Would you like to receive E-Mail notification of new bulletins? Yes *No

E-Mail address is **required if answered YES** to receive notification of MA bulletins: _____

*By answering NO you are agreeing to be responsible to check for new MABs on your own by visiting the following website: <http://www.dpw.state.pa.us/publications/bulletinsearch/index.htm> OR by signing up to receive notification of new MABs through the Listserv option on the DPW website: <http://www.dpw.state.pa.us/provider/index.htm> (select 'eBulletins' Listserv option to join).

If you wish to continue receiving paper bulletins call 1.800.537.8862 option 1 to see if you meet the requirements.

14c. Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

14d. Check this block only if you wish your Medicare claims to crossover to this service location.

14e. Contact Name: _____ Contact Phone: _____

Title: _____

14f. Toll-Free Phone:

()

14g. Fax Number:

()

14h. Contact E-Mail address:

14i. In addition to English do you or your staff communicate with patients in another language?

Yes No

14j. If "Yes", list language(s):

14k. (1) Does the office have exterior or interior steps leading to the main entrance doorway?

Yes No Exterior Interior

(2) If the answer to (1) is yes, does the office have a permanent or portable wheelchair ramp?

Yes No Permanent Portable

(3) If the answer to (1) is yes, is there an alternate entrance that has no exterior or interior steps or has a wheelchair ramp?

Yes No

No exterior steps No interior steps

Permanent ramp Portable ramp

(4) Does the office have an official exemption from the U.S. Department of Justice excusing compliance with Title III of the Americans with Disabilities Act (ADA)? If yes, attach a copy of the exemption to your application.

Yes No

14l. Provider Eligibility Program (PEP). Refer to PEP descriptions and requirements (included with application). **You must choose at least 1 PEP:**

a. _____ b. _____ c. _____

15. Does the provider retain any managing employees or agents? Yes * No

IF "YES" please complete Attachment I (Managing Employee or Agent Disclosure Form) this form can be found on the enrollment website or by following this link:

http://www.dpw.state.pa.us/cs/groups/webcontent/documents/form/p_011861.pdf

16. CONFIDENTIAL INFORMATION

Have you, any agent, or managing employee ever:

A. Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?

Yes No

B. Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?

Yes No

C. Had a controlled drug license withdrawn?

Yes No

D. Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?

Yes No

E. In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

Yes No

16F.

If you answered "Yes" to any of the questions listed above, provide a detailed explanation (on a separate piece of paper) and submit three (3) statements from professional associates or peer review bodies giving factual evidence of why they believe the violation(s) will not be repeated and attach it to your application. Include the following information as applicable to the situation:

- | | |
|--|--|
| 1. Name and title of individual | 8. Disposition/State |
| 2. Name of federal or state health care program | 9. Date license was surrendered |
| 3. Name of licensing/certifying agency taking the action | 10. Name of court |
| 4. Date of action | 11. Date of conviction |
| 5. Type of action taken | 12. Offense(s) convicted of |
| 6. Length of action | 13. Sentence(s) |
| 7. Basis for action | 14. Categorization of offense (i.e. Misdemeanor) |

17.

This form requires the original signature of the authorized representative of the group applying for enrollment.

_____ Title

_____ Printed Name

_____ Original Signature

_____ Date

Mail-To/Pay-To/Home Office Information For The Service Location Entered In 14a

NOTE: Do not use this sheet to add service locations.

18 a. **Address:** Street Suite/Box City State Zip (9-digits) County

b. This address is a:
 Mail-to Pay-to
 Home Office

c. E-Mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone:
()

f. Toll-Free Phone
()

g. Fax Number:

a. **Address:** Street Suite/Box City State Zip (9-digits) County

b. This address is a:
 Mail-to Pay-to
 Home Office

c. E-Mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone:
()

f. Toll-Free Phone
()

g. Fax Number:

a. **Address:** Street Suite/Box City State Zip (9-digits) County

b. This address is a:
 Mail-to Pay-to
 Home Office

c. E-Mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone:
()

f. Toll-Free Phone
()

g. Fax Number:

Group Members

Date: _____

Group 13-Digit Provider #: _____

Group Name: _____

Contact Name: _____ Contact Phone: _____

Note: By Signing, I am agreeing to assign my fees to the Group named, and the service location number listed above. To verify fee-assignment compatibility between provider types, please call the Enrollment Hotline at 1-800-537-8862 prompt 1.

Printed Name	Signature (No Stamp)	Provider Number (13-Digit)	Effective Date
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____

The service location(s) **MUST** be physical street addresses.

Provider Enrollment Group Application Checklist

The following checklist contains the most common reasons Pennsylvania Medicaid Program enrollment applications are returned. Please complete this checklist and **submit it with your application**. Incomplete applications will be returned. **Applications will be scanned – please do NOT staple.**

Did you remember to....

- USE BLACK INK or TYPEWRITE.** Application must be typed or printed in black ink.
- Complete all spaces** as required on the application with either your correct information or N/A.
- Complete the Provider Disclosure/Ownership or Control interest form; found here:**
http://www.dpw.state.pa.us/cs/groups/webcontent/documents/form/p_011861.pdf
- Ensure that you have entered the **correct number of digits** where specified.
- If you have more than 4 taxonomy codes, please attach a separate sheet listing the additional codes.
- Indicate **one primary** provider type, provider specialty and sub-specialty(s), as applicable.
- Include **documentation generated by the Federal IRS** showing the name associated with the FEIN. Remember, a **W-9 is not permissible**.
- Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.
- If applicable, **include a copy** of your:
 - Professional license
 - CLIA certificate
 - Mammography certificate, including the list of mammography certified members and their PROMISe™ 13 digit provider numbers
 - Permit from the Department of Health
 - Any other certification, license, or permit that applies.
- Include a legible copy of the **NPPES Confirmation letter** that shows the NPI Number and Taxonomy(s) assigned to the group applying for enrollment.
- Enter **at least 1** Provider Eligibility Program (PEP).
- Only the **person authorized to represent the group applying for enrollment** can sign and date the **Confidential Information Sheet**. Signature stamp not accepted.
- If you are adding a provider to the group, enter the individual's PROMISe™ 13- digit provider number. The 4-digit service location code must correspond with a valid active street address. We will not assign fees to a service location listed as a P.O. Box.
 - **Fee assignments may only be made between "like provider types". Call the Enrollment Hotline for verification at 1-800-537-8862 prompt 1.**

When completed, review the "Did You Remember..." Checklist included with the application. Then return your application and other documentation to the address listed on the requirements for your specific provider type. If no address is listed on the requirements for your specific provider type/specialty, please mail to:

Mail to: DPW Enrollment PO Box 8045 Harrisburg, PA 17105-8045

Requirements For Provider Type 21 – Case Manager Group

Specialty Code

Please choose from the following list for the specialty and code:

- 076- Peer Support Services
- 211- Medical Assistance Case Management for HIV & AIDS
- 212- Medical Assistance Case Management for under 21
- 213- Early Intervention-Supports Coordination
- 218- MR Targeted Case Management
- 219- Supports Coordination for Persons with Physical Disabilities
- 221- MH Targeted Case Management, Resource Coordination*
- 222- MH Targeted Case Management, Intensive*

*Contact OMHSAS for additional requirements and address for applications – 1-800-433-4459.

Provider Eligibility Program (PEPs)

Please refer to PEP descriptions included in the Group Application instruction for additional requirements and then indicate one or more of the PEPs.

*Contact OMHSAS for additional requirements and address for applications – 1-800-433-4459.

Additional Required Documents For Provider Type 21 (Group)

The following documents and supporting information are required by the Bureau of Fee-for-Service Programs for enrollment:

- Provider Enrollment Group Application
- **You MUST complete the Provider Disclosure/Ownership or Control interest form. This form can be found on the enrollment website or by following this link:**
http://www.dpw.state.pa.us/cs/groups/webcontent/documents/form/p_011861.pdf
- Document generated by IRS that shows the group name and tax ID
- Document that shows how the group is registered with the Department of State or Corporation Bureau
- Approved Service Description
- Case Management Addendum (for the appropriate specialty)

Submission Address

After completion of all enrollment documents, send the complete package to:

<u>Specialty 211, 212, 218 and 219</u>	<u>Specialty 221 and 222</u>	<u>Specialty 213</u>
Department of Public Welfare Enrollment Unit PO Box 8045 Harrisburg, PA 17105-8045	DPW/OMHSAS Provider Enrollment Unit DGS Annex Complex Bldg #31, Shamrock Hall, 2 nd Fl. 112 E. Azalea Drive Harrisburg, PA 17110-3594	DPW/Office of Child Development Health & Welfare Room 525 PO Box 2675 Harrisburg, PA 17105-2675

Case Management Addendum

211- HIV Case Management

Select the target group(s) you will case manage:

_____ AIDS/Symptomatic HIV

_____ Technology Dependent Children
Under Michael Dallas Waiver

List additional counties you wish to serve if any:

1. _____ 2. _____ 3. _____ 4. _____

Attach documentation to verify that you meet the education and work experience requirements.

- Documentation of education can be in the form of an Undergraduate or Graduate level diploma, college transcripts, or an official description of a course of study. A Case Manager must meet the minimum education requirement of completion of 12 semester hours in psychology, sociology, or other social welfare course.
- Documentation of case management work experience can be in the form of a detailed resume and job descriptions signed and dated by you and your supervisor at the time of applicable experience. If a job description is unavailable, a letter from your supervisor at the time of applicable experience, which details your job duties and responsibilities, may be submitted for review.

For MSW/MSS/BSW/BWW Degrees, a copy of your degree, CM training, and CM experience **must be attached**.

For MSN and BSN Degrees, a copy of your degree, Pennsylvania License, CM training, and CM experience **must be attached**.

For RN Diplomas/Nursing Associate Degree, a copy of your diploma and Pennsylvania RN License and documented CM training, CM experience, and experience with the targeted group you intend to case manage **must be attached**. Your college transcript must include a combination of 12 semester hours of psychology, sociology, or other social welfare courses.

List the name(s), address(es), and telephone number(s) of a reference person(s) familiar with your CM experience an experience with the target group.

Submittal Address:

DPW/OMAP
Provider Enrollment Unit
P.O. Box 8045
Harrisburg, PA 17105-8045

Case Management Addendum

212- Under Age 21

Attach documentation to verify that you meet the education and work experience requirements.

- Documentation of education can be in the form of an Undergraduate or Graduate level diploma, college transcripts, or an official description of a course of study. A Case Manager must meet the minimum education requirement of completion of 12 semester hours in psychology, sociology, or other social welfare course.
- Documentation of case management work experience can be in the form of a detailed resume and job descriptions signed and dated by you and your supervisor at the time of applicable experience. If a job description is unavailable, a letter from your supervisor at the time of applicable experience, which details your job duties and responsibilities, may be submitted for review.

For MSW/MSS/BSW/BWW Degrees, a copy of your degree, CM training, and CM experience **must be attached**.

For MSN and BSN Degrees, a copy of your degree, Pennsylvania License, CM training, and CM experience **must be attached**.

For RN Diplomas/Nursing Associate Degree, a copy of your diploma and Pennsylvania RN License and documented CM training, CM experience, and experience with the targeted group you intend to case manage **must be attached**. Your college transcript must include a combination of 12 semester hours of psychology, sociology, or other social welfare courses.

List the name(s), address(es), and telephone number(s) of a reference person(s) familiar with your CM experience an experience with the target group.

Submittal Address:

DPW/OMAP
Provider Enrollment Unit
P.O. Box 8045
Harrisburg, PA 17105-8045

Case Management Addendum

213- Early Intervention

Attach documentation to verify that you meet the education and work experience requirements.

- Documentation of education can be in the form of an Undergraduate or Graduate level diploma, college transcripts, or an official description of a course of study. A Case Manager must meet the minimum education requirement of completion of 12 semester hours in psychology, sociology, or other social welfare course.
- Documentation of case management work experience can be in the form of a detailed resume and job descriptions signed and dated by you and your supervisor at the time of applicable experience. If a job description is unavailable, a letter from your supervisor at the time of applicable experience, which details your job duties and responsibilities, may be submitted for review.

For MSW/MSS/BSW/BWW Degrees, a copy of your degree, CM training, and CM experience **must be attached**.

For MSN and BSN Degrees, a copy of your degree, Pennsylvania License, CM training, and CM experience **must be attached**.

For RN Diplomas/Nursing Associate Degree, a copy of your diploma and Pennsylvania RN License and documented CM training, CM experience, and experience with the targeted group you intend to case manage **must be attached**. Your college transcript must include a combination of 12 semester hours of psychology, sociology, or other social welfare courses.

List the name(s), address(es), and telephone number(s) of a reference person(s) familiar with your CM experience an experience with the target group.

Submittal Address:

DPW/Office of Child Development
Health & Welfare Room 525
PO Box 2675
Harrisburg, PA 17105-2675

Case Management Addendum

218- MR Targeted Services

Mental Retardation Targeted Services Management

Effective date of enrollment: _____

The following additional attachments are needed to complete the package:

- County Negotiated Rate
- Two Provider Agreements with original signatures

Mental Retardation Targeted Services Management Services Include:

MR Targeted Services Management (TSM)

<u>Old Code</u>	<u>New Code</u>	<u>Modifier</u>
W9068	T1017	n/a

Submittal Address:

DPW
P.O. Box 2675
Harrisburg, PA 17105-2675
Attention: TSM unit

Case Management Addendum

219- Supports Coordination for Persons with Physical Disabilities

Attach documentation to verify that you meet the education and work experience requirements.

- Documentation of education can be in the form of an Undergraduate or Graduate level diploma, college transcripts, or an official description of a course of study. A Case Manager must meet the minimum education requirement of completion of 12 semester hours in psychology, sociology, or other social welfare course.
- Documentation of case management work experience can be in the form of a detailed resume and job descriptions signed and dated by you and your supervisor at the time of applicable experience. If a job description is unavailable, a letter from your supervisor at the time of applicable experience, which details your job duties and responsibilities, may be submitted for review.

For MSW/MSS/BSW/BWW Degrees, a copy of your degree, CM training, and CM experience **must be attached**.

For MSN and BSN Degrees, a copy of your degree, Pennsylvania License, CM training, and CM experience **must be attached**.

For RN Diplomas/Nursing Associate Degree, a copy of your diploma and Pennsylvania RN License and documented CM training, CM experience, and experience with the targeted group you intend to case manage **must be attached**. Your college transcript must include a combination of 12 semester hours of psychology, sociology, or other social welfare courses.

List the name(s), address(es), and telephone number(s) of a reference person(s) familiar with your CM experience an experience with the target group.

Submittal Address:

DPW/OMAP
Provider Enrollment Unit
P.O. Box 8045
Harrisburg, PA 17105-8045

Case Management Addendum

221- MH/Resource Coordination

Mental Health Resource Coordination Services

Effective Date of Enrollment: _____

Date of Site Survey: _____

Begin Date of Site Survey: _____

Ending Date of Site Survey: _____

Funding Source:

HealthChoices Only: [] Fee-For-Service: [] Both: []

The following additional attachments are needed to complete package:

- Letter of Support from County Confirming Funding Source Choices Above
- Certificate of Compliance (with attached letter)
- Two Provider Agreements with original signatures
- Blended Model Waiver Approval (if applicable)

Submittal Address:

DPW/OMHSAS
Bureau of Operations & Quality Management
HSH Complex
Shamrock Hall, Bldg #31
2101 Cameron & McClay Streets
Harrisburg, PA 17105

Case Management Addendum

222-MH/Intensive

Mental Health Intensive CM Services

Effective Date of Enrollment: _____

Date of Site Survey: _____

Begin Date of Site Survey: _____

Ending Date of Site Survey: _____

Funding Source:

HealthChoices Only: [] Fee-For-Service: [] Both: []

The following additional attachments are needed to complete package:

- Letter of Support from County Confirming Funding Source Choices Above
- Certificate of Compliance (with attached letter)
- Two Provider Agreements with original signatures
- Blended Model Waiver Approval (if applicable)

Submittal Address:

DPW/OMHSAS
Bureau of Operations & Quality Management
HSH Complex
Shamrock Hall, Bldg #31
2101 Cameron & McClay Streets
Harrisburg, PA 17105

ADDENDUM- PEER SUPPORT SERVICES (Specialty 076)

Required Documents:

- PROMISE Provider Enrollment Base Application
- Signed Outpatient Provider Agreement
- Copy of Tax Document generated by the IRS showing both the name and tax ID of the entity applying for enrollment
- Copy of Certificate of Compliance (If ICM or RC, copy of FO letter of approval) OR Letter of Approval to operate as Peer Support Services
- Copy of approved service description
- Signed Supplemental Provider Agreement for Peer Support Services
- Copy of Subcontract Agreement (for subcontracted providers only)

Submit Enrollment Packet to the appropriate OMHSAS Field Office:

Northeast Field Office OMHSAS
Scranton State Office Bldg
100 Lackawanna Avenue Room 321
Scranton, PA 18503-1939

Southwest Field Office OMHSAS
Pittsburgh State Office Bldg
300 Liberty Avenue Room 413
Pittsburgh, PA 15222-1210

Southeast Field Office OMSHAS
Norristown State Hospital
1001 Sterigere Street B
Bldg 57 1st Floor Room 105
Norristown, PA 17401-5397

Central Field Office OMHSAS
Logan Vista Dome
PO Box 2675
Harrisburg, PA 17105-2675

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE
Office of Medical Assistance Programs

**SUPPLEMENTAL PROVIDER AGREEMENT FOR THE
DELIVERY OF PEER SUPPORT SERVICES**

This Supplemental Provider Agreement sets forth the responsibilities of the peer support services provider (“Provider”), which are in addition to those set forth in the Medical Assistance Outpatient Provider Agreement and addendums to that agreement, and the Provider handbooks and supplements.

Provider agrees to deliver services in accordance with the service description approved by the Office of Mental Health and Substance Abuse Services (“OMHSAS”).

Provider agrees to provide on-site services in a facility that:

- a. Affords adequate space, equipment and supplies in order that services be provided effectively and efficiently and with sufficient privacy when necessary.
- b. Is in a location that is accessible and convenient to the service population and is accessible to persons with disabilities.
- c. Meets applicable federal, state and local requirements for fire, safety and health.

Provider agrees to develop written policies, program guidelines and procedures relating to peer support services in accordance with the Peer Support Services Bulletin, Medical Assistance Provider Handbook, this Supplemental Provider Agreement and Provider’s approved service description.

Provider agrees to ensure that a Recovery-focused Individual Service Plan (“Individual Service Plan”) is developed by the individual, the peer specialist and the mental health professional within one month of enrollment and reviewed every six months thereafter and that the initial Individual Service Plan and each review are signed by the individual, the peer specialist and the mental health professional.

Provider agrees that each Individual Service Plan will specify individualized goals and objectives pertinent to the individual’s recovery and community integration in language that is outcome oriented and measurable; identify interventions directed to achieving the individualized goals and objectives; specify the peer specialist’s role in relating to the individual and involved others; and specify the frequency of peer support services to be delivered.

Provider agrees to deliver services in accordance with the Individual Service Plan.

Provider agrees that in order to achieve the agreed-upon goals in the Individual Service Plan, and with the individual’s consent, the peer specialist will work with the individual’s family, service and treatment providers, rehabilitative programs and natural community supports.

Provider agrees that it will typically provide peer support services on an individual (1:1) basis but may offer group services for several individuals together when such services are beneficial, provided that group services may not include social, recreational or leisure activities. To receive peer support services in a group, individuals must share a common goal, and each individual must agree to participate in the group. Services such as psychoeducation or WRAP (Wellness Recovery Action Planning) are the types of services that may be provided in groups.

Provider agrees to insure that attempts are made to contact the individual according to the Individual Service Plan.

Provider agrees to administer and deliver peer support services in accordance with the following staffing and supervision requirements:

- a. Each peer support program will be identified separately from other services or programs offered by the provider and will have a designated supervisor and staff.
- b. Peer support staff, including supervisors, may work in another program or agency, but their time will be pro-rated and their hours of service in each service clearly and separately identified. No staff person may have duplicate or overlapping hours of service in a peer support program and another program or agency. Peer support staff will disclose (to appropriate program management/administration) when they are co-employed with another program or agency.
- c. The ratio of staff to individuals served is to be based upon the needs of the population served and program location (urban vs. rural).
- d. A mental health professional is to maintain clinical oversight of peer support services, which includes ensuring that services and supervision are provided consistent with the service requirements.
- e. A full time equivalent ("FTE") supervisor may supervise no more than seven FTE peer specialists.
- f. Supervisors will conduct at least one face-to-face meeting with each peer specialist per week with additional support as needed or requested.
- g. Supervisors will maintain a log of supervisory meetings.
- h. Peer specialists will receive at least six hours of direct supervision and mentoring from the supervisor in the field before working independently off-site.

Provider agrees to ensure that Provider staff meet the following minimum qualifications:

- a. A supervisor of peer specialists is either a mental health professional who has completed the peer specialist supervisory training, which is offered in accordance with guidelines defined by the Department, or an individual who has the following minimum qualifications:
 - (i) A bachelor's degree; and
 - (ii) Two years of mental health direct care experience, which may include experience in peer support services;

OR

 - (i) A high school diploma or general equivalency degree; and
 - (ii) Four years of mental health direct care experience, which may include experience in peer support services, and the completion of a peer specialist supervisory training curriculum approved by the Department within 6 months of assuming the position of peer support supervisor.
- b. A peer specialist is a self-identified individual who has received or is receiving state priority group services as defined in MH Bulletin OMH-94-04, Serious Mental Illness: Adult Priority Group, and who:
 - (i) Has a high school diploma or general equivalency degree; and
 - (ii) Within the last three (3) years, has maintained at least 12 months of successful full or part-time paid or voluntary work experience or obtained at least 24 credit hours of post-secondary education; and
 - (iii) Has completed a peer specialist certification training curriculum approved by the Department.

Provider agrees to develop a written staff training plan that ensures that each practitioner in the peer support program receives training appropriate to his or her identified needs and the position requirements specified in this paragraph. The training plan will identify training objectives that address the enhancement of knowledge and skills as well as the provision of services in an age-appropriate and culturally competent manner and ensure that staff attain and maintain peer specialist certification.

- a. Mental health professionals who assume responsibility for supervision of peer support services will complete a peer specialist supervisory orientation/training course approved by the Department.
- b. Supervisors who are not mental health professionals will complete a peer specialist supervisory orientation/training course approved by the Department.
- c. The supervisor's orientation/training course will be completed within 6 months of assuming the position of peer specialist supervisor.

- d. Peer specialists will complete a peer specialist certification training curriculum approved by the Department before providing peer support services.
- e. Peer specialists will complete 18 hours of continuing education training per year with 12 hours specifically focused on peer support or Recovery practices, or both, in order to maintain peer specialist certification.

Provider agrees to maintain a written record of training attended by each peer support staff classification (Administrator/Program Director, Mental Health Professional, Peer Specialist Supervisor, Certified Peer Specialist).

Provider agrees to ensure that peer specialists within the agency are given opportunities to meet with or otherwise receive support from other peer specialists both within and outside the agency.

Provider agrees to have written protocols that address coordination of services with other appropriate mental health treatment, rehabilitation, and co-occurring disorder programs, including substance abuse services, as well as medical services, community resources and natural supports and document linkages with such other resources. With the individual's written consent, such coordination includes periodic peer support progress reports to the referral source and treatment providers.

Provider agrees to have written protocols that describe how the certified peer specialist and certified peer specialist supervisor will participate in and coordinate with treatment teams at the request of a consumer and the procedure for requesting team meetings.

Provider agrees to make available to participants a list of culturally competent resources related to housing, leisure, legal entitlements, emergency needs, physical health and wellness, mental health treatment and co-occurring disorders.

Provider agrees to make available to participants, based upon individual need, information regarding substance abuse services and support groups, including but not limited to Dual Recovery Anonymous, Alcoholics Anonymous and Narcotics Anonymous.

Provider agrees that its quality assurance plan will include a written Continuous Quality Improvement ("CQI") plan, as described in this paragraph, addressed to the delivery of peer support services, which is reviewed and updated annually. Provider agrees to include participation from individuals receiving peer support services in both the development of the CQI plan and the annual reviews.

- a. The CQI plan will describe how Provider will:
 - (i) Identify and work to eliminate organizational, systemic and community barriers that may interfere with the ability of the peer specialist to perform his or her primary job responsibilities.
 - (ii) Promote a spirit of collaboration and partnership among the provider, the peer specialist and community stakeholders.
- b. The CQI plan will describe procedures for ongoing review of the plan and for a systematic review of services and outcomes, including review of Individual Service Plans, to ensure quality, timeliness and appropriateness of services and individual satisfaction with services. The procedures will describe the types and frequency of reviews to be undertaken (e.g., quarterly professional staff conferences, peer reviews, case reviews conducted by internal or external individuals or entities).
- c. The CQI plan will include an annual report that describes the population served and the outcome of the reviews conducted through the year, including the progress made or not made in meeting the goals specified in the plan, and provider agrees to disseminate the report to OMHSAS, provider staff, the agency director, the County MH/MR Administrator, the behavioral health managed care organizations in which the provider is enrolled and consumers and their families.

Provider agrees to treat, and to insure that its staff treats, information about individuals who are receiving peer support services as confidential as required by regulations at 55 Pa.Code §§ 5100.31 - 5100.39 (relating to confidentiality of mental health records), and the Health Insurance Portability and Accountability Act (HIPAA), Pub. L. 104-191, and accompanying regulations at 45 C.F.R. Part 164 (relating to security and privacy).

Provider agrees that it will make no service decisions in violation of the individual's civil rights as set forth in 55 Pa.Code §§ 5100.53 - 5100.56 (relating to patient rights).

Provider agrees to insure that individuals receiving peer support services are informed of their rights, including their right not to be discriminated against on the basis of age, race, sex, religion, ethnic origin, economic status, sexual preference, or diagnosis, and their right to appeal a decision to reduce or terminate peer support services over the individual's objection.

Provider agrees to submit reports as required by the Department, county MH/MR administrator and appropriate behavioral health managed care organizations.

If Provider is providing peer support services through a subcontractor that is not enrolled in the Medical Assistance Program, Provider agrees to be responsible for the clinical and administrative oversight of the services delivered by the subcontractor and for compliance with program requirements.

I hereby agree to comply with the terms of this Supplemental Provider Agreement, the Peer Support Services Bulletin, the Medical Assistance Provider Handbook, and all requirements that govern participation in the Medical Assistance Program:

Provider Name (please type or print)

Provider Signature

Date

Provider Address (please type or print)