

## Requirements For Provider Type 21 – Case Manager

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### 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 Case Management
- 219- Supports Coordination for Persons with Physical Disabilities
- 221- MH Targeted Case Management, Resource Coordination
- 222- MH Targeted Case Management, Intensive

### Provider Eligibility Program (PEPs)

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

### Additional Required Documents For Provider Type 21

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

- Provider Enrollment Application
- Signed Outpatient Provider Agreement
- **\*\*\*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](http://www.dpw.state.pa.us/cs/groups/webcontent/documents/form/p_011861.pdf)
- Copy of Federal IRS generated paperwork that shows both name and SSN/FEIN of entity applying for enrollment
- If the Social Security card states “Valid for work only with INS authorization”, please submit the paperwork generated by the INS or Department of Homeland Security that shows proof of authorization to work in the United States.
- Case Management Addendum (for the appropriate specialty)
- Refer to the Case Management Addendum of your specialty for additional requirements
- Proof of home state Medicaid participation (out of state providers).
- Copy of the **NPPES Confirmation letter** that shows the NPI Number and Taxonomy(s) assigned to the individual applying for enrollment. (**excluding specialty 211**).

### Submittal Address

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

<u>Specialty 211, 212 and 219</u>	<u>Specialties 076, 221 and 222</u>	<u>Specialty 213 and 218</u>
Department of Public Welfare Enrollment Unit PO Box 8045 Harrisburg, PA 17105-8045	Send to address indicated on the addendum for your specific specialty.	DPW/Office of Child Development Health & Welfare Room 525 PO Box 2675 Harrisburg, PA 17105-8045

## Case Management Addendum

### **211- HIV Case Management**

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  
or  
222- MH/Intensive Case Management  
or  
222- Blended Case Management**

**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)
- Provider Agreement with original signatures
- Blended Model Waiver Approval (if applicable)

**Submittal Address:**

DPW/OMHSAS  
Provider Enrollment Unit  
DGS Annex Complex PO Box 2675  
Bldg #31, Shamrock Hall, 2<sup>nd</sup> Fl.  
Harrisburg, PA 17110-3594

## **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
- If the Social Security card states “Valid for work only with INS authorization”, please submit the paperwork generated by the INS or Department of Homeland Security that shows proof of authorization to work in the United States.
- 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 1<sup>st</sup> 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)**