pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF LONG TERM LIVING

Home and Community Based Waiver Services
Provider Enrollment Information Form

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

☐ ACT 150 ☐ Community HealthChoices ☐ 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

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) **(Revalidation Only)**
☐ Respite

Do you have a Home Health Agency license from the Dept. of Health and Medicare Certification? 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:

Requires Home Health Agency License

☐ Home Health Aide
☐ Home Health-Nursing (LPN)
☐ Home Health-Nursing (RN
☐ Cognitive Therapy
☐ Behavioral Therapy
☐ Counseling Services
☐ Nutritional Counseling

Requires Home Health Agency or Outpatient or Community-Based Rehabilitation Agency

☐ Home Health-Occupational Therapy
☐ Home Health-Occupational Therapy - Assistant
☐ Home Health-Physical Therapy
☐ Home Health-Physical Therapy - Assistant
☐ Home Health-Speech & Language Therapy

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:

☐ Career Assessment
☐ Job Coaching
☐ Job Finding
☐ Employment Skills
☐ Benefits Counseling
☐ 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, Contractor, or Equipment, Technology and Modifications Agency or Specialist)*
☐ Community Transition Services ***(OBRA Waiver ONLY)***
☐ Home Adaptations *(Contractor's license if required by trade or Durable Medical Equipment provider)*
☐ Home Delivered Meals *(Home Delivered Meals Vendors))*
☐ Non-Medical, Non-Emergency Transportation *(Individual Driver, Licensed Transportation Agency, Public Transit Authority)*
☐ Personal Emergency Response System (PERS) Installation **and** Maintenance *(Vendors of Personal Emergency Response Systems, Home Health Agency, Durable Medical Equipment and Supply Company)*
☐ Vehicle Modifications (*Quality Assurance Program Accreditation by the National Mobility Equipment Dealers Assoc.)*
☐ Specialized Medical Equipment and Supplies (*Durable Medical Equipment, Pharmacy, or Hearing Aid Dealer*)
☐ Pest Eradication (Pest Company license required) ***(CHC ONLY)***
☐ Telecare Services *(please select one below)* ***(CHC ONLY)***
- ☐ Health Status Measuring and Monitoring (*Home Health Agency license from Dept. of Health*)
- ☐ Activity & Sensor Monitoring (*Home Health Agency, Drug & Device Certification, Pharmacy or Hospital license from the Dept. of Health*)
- ☐ Medication Dispensing & Monitoring (*Home Health Agency, Drug & Device Certification, Pharmacy or Hospital license from the Dept. of Health*)

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:

☐ Residential Habilitation in a 1-3 group setting
- ☐ Res. Habilitation Supplemental for 1:1
- ☐ Res. Habilitation Supplemental for 2:1

☐ Structured Day Habilitation-Group
- ☐ Structured Day Supplemental for 1:1
- ☐ Structured Day Supplemental for 2:1

☐ Residential Habilitation in a 4-8 group setting
- ☐ Res. Habilitation Supplemental for 1:1
- ☐ Res. Habilitation Supplemental for 2:1

(Must also be licensed as a Personal Care Home)

These services are available in the Community HealthChoices 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
- ☐ Venango
- ☐ Lawrence
- ☐ McKean
- ☐ Mercer
- ☐ Potter
- ☐ Warren

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

Region 4
☐ All Region 4Counties
- ☐ 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 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).

Will your agency provide any of the selected services in any of the following settings?

1. ***Nursing Facility*** ***YES*** ☐ ***NO*** ☐
2. ***Institution for Mental Diseases*** ***YES*** ☐ ***NO*** ☐
3. ***Public or Private ICF/ID*** ***YES*** ☐ ***NO*** ☐
4. ***Hospital*** ***YES*** ☐ ***NO*** ☐

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).

Will your agency provide any of the selected services in a publicly or privately operated facility that provides inpatient institutional treatment? ***YES*** ☐ ***NO*** ☐

Will 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*** ☐

Will your agency provide any of the selected services in any of the following settings?

1. ***Farmstead or disability-specific farm community*** ***YES*** ☐ ***NO*** ☐
2. ***Gated/secured community for people with disabilities*** ***YES*** ☐ ***NO*** ☐
3. ***Residential school*** ***YES*** ☐ ***NO*** ☐

Do you own, rent/lease, or operate a residential setting (i.e. licensed or unlicensed) at this location where services are provided? ***YES*** ☐ ***NO*** ☐

Does any owner with greater than 50% or more controlling interest of the agency own, rent, or lease, any of the homes/apartments where participants reside? ***YES*** ☐ ***NO*** ☐

Will your agency provide any of the selected services in this location that is designed to offer multiple services and activities onsite? ***YES*** ☐ ***NO*** ☐

Are there other buildings located on these grounds, which also provide services and activities?
YES ☐ ***NO*** ☐

Please describe the space where the service will be provided:

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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.
https://www.dhs.pa.gov/Services/Disabilities-Aging/Pages/Alternatives-to-Nursing-Homes.aspx