

Ohio Department of Medicaid
**OHIO HOME CHOICE DEMONSTRATION PROGRAM PROVIDER
 ENROLLMENT APPLICATION/TIME LIMITED AGREEMENT**
Community Living Specialist Service

Submit completed signed application/agreement with required attachments to

Ohio HOME Choice Demonstration Program
 Provider Application Processing
 P.O. Box 182709
 Columbus, Ohio 43218-2709

(For State Use Only)

Provider Type

Agency Providers

- PASSPORT Administrative Agency
- Center for Independent Living
- Brain Injury Association of Ohio
- Ohio Department of Mental Health Approved Provider Agency
- County Board of DD/Council of Government
- Ohio Department of Medicaid Approved Provider Agency

Provider Identification (Please print or type entries)

Agency Name			
EIN Number *		Current or previous Medicaid Number(s) (if applicable)	
Current NPI Number (if applicable)**		License Number ***	License Expiration Date (mm/dd/yyyy)

- *You must attach a completed and signed W-9 form. Do not use GROUP tax ID number.
- **You must attach a copy of the notice from the NPI Enumerator to verify the NPI Number.
- ***You must attach a copy of your current state board license.

Service Location of Practice/Business (Please print or type entries)

(Please complete an application for each physical location of practice or business. Non-agency providers can use home address if applicable)

Name/ Building Name/ or Department/ or In care of			
Physical Address (Number, Street, Avenue or Route) (P.O. and Drop Boxes are not acceptable)			Suite Number
City	County	State	Zip Code (Zip +4, if possible)
Telephone Number	Cell Phone Number	Email Address	

"Pay to" Address (Name & Address to which all other material is to be mailed)

Leave blank if address is the same as "Service Location of Practice/Business"

Name			
Address			Suite Number
City	State		Zip Code (Zip +4, if possible)

Mailing/Correspondence Address (Name & Address to which all other material is to be mailed)

Leave blank if address is the same as "Service Location of Practice/Business"

Name			
Address			Suite Number
City	County	State	Zip Code (Zip +4, if possible)

Disclosure and Ownership/Control Interest Statement

Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations in spaces provided. List any additional names and addresses on the proper section of the sheet provided.

1. Have you or any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organization, agency, or professional association been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX? YES NO

Name (Who was it?)	Type of Offense and Disposition	When? Give date (mm/dd/yyyy)	SSN/EIN
Name (Who was it?)	Type of Offense and Disposition	When? Give date (mm/dd/yyyy)	SSN/EIN

2. Have you or any directors, officers, agents or managing employees of the institution, agency, organization, or professional association ever been indicted or convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, XX? YES NO

Name (Who was it?)	Type of Offense and Disposition	When? Give date (mm/dd/yyyy)	SSN/EIN
Name (Who was it?)	Type of Offense and Disposition	When? Give date (mm/dd/yyyy)	SSN/EIN

3. List names, addresses, AND SSNs for individuals, and the names, address, and Employer Identification Number (EIN) for organizations having direct or indirect ownership or a controlling interest in the entity or practice. Place an "X" in the box labeled "Related" for all listed individuals who are related to each other.

Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN

4. Type of Entity or Practice

- Sole Proprietorship (Non-agency provider)
 Partnership
 Corporation
 Unincorporated Association
 Professional Corporation/Association
 Non-profit
 Other (specify)

5. If the disclosing entity is a corporation, list names, addresses, and SSNs of the Directors and the name, address, and EIN of the parent corporation, if applicable.

Name	Address	SSN/EIN

Disclosure and Ownership/Control Interest Statement (Continued)

Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations in spaces provided. List any additional names and addresses on the proper section of the sheet provided.

6. Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership, or Members of the Board of Directors.) If yes, list names, addresses of individuals, and provider numbers. If under Title XIX, list vendor number. YES NO

Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number

7. Has there been a change in ownership or control within the last year? If yes, when? (mm/dd/yyyy) YES NO
 If "YES", when? (mm/dd/yyyy) **IF YES, ATTACH EXPLANATION**

8. Do you anticipate any change in ownership or control within the year? If yes, when? (mm/dd/yyyy) YES NO
 If "YES", when? (mm/dd/yyyy) **IF YES, ATTACH EXPLANATION**

9. Is this entity operated by a management company, or leased in whole or part by another organization? YES NO
 If "YES", give data of change of operations. (mm/dd/yyyy) **IF YES, ATTACH EXPLANATION**

10. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? YES NO

11. Is this entity affiliated with a chain? (If yes, list name, address of Corporation, and EIN number.) YES NO

Name	Address	Employer Identification Number (EIN)
------	---------	--------------------------------------

12. **Have you or the entity ever been sanctioned by the Medicare or Medicaid Program?** YES NO
 If "YES", when? (mm/dd/yyyy) How long? (mm/dd/yyyy) **IF YES, ATTACH EXPLANATION**

Who was it? Give name(s)	When? Give date (mm/dd/yyyy)	SSN/EIN
Who was it? Give name(s)	When? Give date (mm/dd/yyyy)	SSN/EIN

13. Have you or any Directors, Officers, Agents, or Managing Employees of the Institution, Agency, or Organization ever been indicted or convicted of a violation of State or Federal Law? YES NO

Name	Type of Offense and Disposition	When, give date? (mm/dd/yyyy)	SSN/EIN
------	---------------------------------	-------------------------------	---------

All providers must read the statements below, print name, initial, and date.

In accordance with Executive order 2007-01S, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2007-01S, (2) has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Executive Order 2007-01S is, in itself, grounds for termination of this contract or grant and may result in the loss of other contracts or grants with the State of Ohio.

Name and Title *(please print)*

Initial

Date

A copy of Executive Order 2007-01S can be found on our website at:

<http://www.medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment.aspx>

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary, as appropriate.

Name and Title *(please print)*

Initial

Date

Ohio HOME Choice Demonstration Program Provider Agreement [For providers of Community Living Specialist Service (CLS) – Minimum Data Set 3.0 Section Q]

This provider agreement is a contract between the Ohio Department of Medicaid (the Department) and the undersigned provider of HOME Choice Demonstration Program services (the Provider) in which the Provider agrees to comply with the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and agrees to the following:

1. The CLS shall perform the following tasks upon acceptance of a referral for assistance from a person residing in an Ohio nursing facility with Medicaid as a payer source:
 - a. For purposes of a phone contact with resident, all of the following tasks are to be completed:
 - i. The CLS shall contact the nursing facility (NF) and the resident (and guardian, if applicable) by phone within 3 days of the receipt of the referral by the HOME Choice Intake and Care Coordination Unit (HCICCU). The CLS will access the Connect Me Ohio website and other internet resources and will identify the resident's discharge goals, previous efforts within the community, and identify any informal support systems using the Ohio Community Living Guide.
 - ii. The CLS shall provide, via phone or mail, a list and source for applications to necessary programs, phone numbers needed to assure continuity of care and any steps needed to locate and secure housing and accommodations. The CLS shall notify the NF of the potential for transition to community living.
 - b. For purposes of a Face to Face meeting with resident, all of the following tasks are to be completed:
 - i. Complete steps under 1(a)(i) above.
 - ii. The CLS shall schedule a face to face meeting with the resident, his/her family/guardian (when applicable) and the nursing facility discharge planner (when requested by the resident) to identify resources to facilitate the resident's discharge goals and preferences (Medicaid and non-Medicaid). The CLS shall perform the face to face meeting within 10 working days of HOME Choice Intake and Care Coordination Unit (HCICCU) notification and CLS acceptance of a referral.
 - iii. The CLS shall establish next steps through the completion of a Community Living Plan which includes, but is not limited to, a list and source for applications to necessary programs, phone numbers needed to assure continuity of care, and any steps needed to locate and secure housing and accommodations.
 - iv. At the conclusion of the meeting, the CLS shall have the resident sign the Community Living Plan addendum verifying that the face to face meeting occurred.
 - v. At the conclusion of the meeting or within 5 working days following the meeting, the CLS shall provide the resident and the nursing facility with a copy of the written Community Living Addendum as signed by the resident and the CLS. The CLS shall also provide the resident the Community Living Plan and a copy of the HOME Choice Relocation Workbook.
 - vi. The CLS shall assist the resident in making initial contacts with potential resources during and/or following the face to face meeting as needed.
 - vii. If the resident requires transition coordination and meets HOME Choice Transition Program eligibility requirements, the CLS shall assist the person in completing the application and ensure that the HOME Choice Intake and Care Coordination Unit receives the application for processing.
 - c. Within 5 working days of the face to face meeting or the phone contact/conversation with the resident, the CLS shall submit a copy of the Community Living Plan Addendum to Medicaid prior to release of payment by the fiscal intermediary. The CLS provider may only bill, per individual for either the Face to Face meeting or the phone contact/conversation with the resident not both.
 - d. The CLS agrees to accept \$150 per resident face to face meeting or \$30 per resident phone contact/conversation as payment in full for the tasks outlined in this provider agreement for Medicaid residents of Ohio nursing facilities.
2. The CLS shall perform the following tasks upon acceptance of a referral for assistance from a resident residing in an Ohio nursing facility with non-Medicaid payer source(s):
 - a. The CLS shall contact the nursing facility and the resident, at a minimum *by phone*, and begin research using the Connect Me Ohio website and other website sources. The CLS identifies the resident's discharge goals, previous efforts within the community, and any informal support systems.
 - b. The CLS shall identify resources to facilitate the resident's discharge goals and preferences (Medicaid and non-Medicaid).
 - c. The CLS shall provide, *via mail*, a list and source for applications to necessary programs, phone numbers needed to assure continuity of care, and any steps needed to locate and secure housing and accommodations. The CLS shall notify the nursing facility of the potential for transition to community living.
 - d. The CLS agrees to perform tasks outlined in this provider agreement for at least 20 percent of the weekly referrals accepted and will not seek payment from the HOME Choice Demonstration Program for non-Medicaid residents of Ohio nursing facilities.
 - e. The CLS agrees to submit a monthly file of activities to the HCICCU by the 15th of each month for referrals received the previous month.
3. For consistency and continuity of care, each CLS shall use the Connect Me Ohio website, at a minimum.
4. Each CLS shall follow all Medicaid approved processes including the procedures outlined in the Ohio Community Living Guide and shall document activities using Medicaid approved forms.

5. Render Community Living Specialist services in accordance with this agreement, submit claims only for Medicaid residents and services actually performed, and bill the Department in accordance with rule 5101:3-51-06 of the Administrative Code.
6. Follow all Medicaid-approved reimbursement policies and procedures established for the HOME Choice Demonstration Program, including timely submission of claims.
7. Accept the allowable reimbursement for Community Living Specialist services for Medicaid residents of Ohio nursing facilities as payment-in-full and not seek reimbursement for the services from the resident, authorized representative, any member of the family, or any other person. Follow all Medicaid-approved reimbursement policies and procedures established for the HOME Choice Fiscal Management Services (FMS), including timely submission of claims.
8. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The Provider shall maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer.
9. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Health Care Fraud Section of the Ohio Attorney General, or their designees, any information maintained under paragraph 4 above for audit or other purposes upon request. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of HOME Choice Demonstration Program payments and may result in termination from the HOME Choice Demonstration Program.
10. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; additions; deletions, physical, mail-to, pay-to or email address; and phone number.
11. Disclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5101:3-51-03 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX Services. The provider shall also comply with the criminal record check requirements set forth in Rule 5101:3-51-03 of the Administrative Code.
12. Neither the provider, nor the organization, nor any owner, director, officer, employer of the organization, or any provider retained by the organization or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title XX beneficiaries.
13. Follow the regulations and policies set forth in Chapter 5101:3-51 of the Administrative Code.
14. Provide to the Department, through the court of jurisdiction, notice of any action brought by the Provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to the **Office of Legal Services, Ohio Department of Medicaid, P.O. Box 182709, Columbus, Ohio 43218-2709.**
15. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d), and Chapter 5101:3-51 of the Administrative Code.
16. Comply with all provisions outlined in the Minimum Data Set Medicaid Agency Data Use Agreement (DUA). The Provider shall not, unless explicitly provided for under contract, disclose, release, reveal, show, sell, rent, lease, loan, or otherwise grant access to the data covered by the Agreement to any person(s). The Provider acknowledges that criminal penalties under the Social Security Act, the Privacy Act and the United State code, which govern the use of these data, may apply to disclosures of information covered by the Agreement. Failure to comply with all provisions outlined in the DUA shall result in termination of the provider agreement.

The HOME Choice Demonstration Program is not a Medicaid program. This agreement does not permit the Provider to furnish medical assistance services through the Ohio Medicaid Program.

I further certify that I am the officer, chief executive officer, or general partner of the organization that is applying for this HOME Choice Demonstration Program provider agreement. I further agree to be bound by this agreement, and certify that the information I have given on this application is true and accurate.

This agreement may be canceled by either party upon written notice to the other party no less than 30 days prior to the termination date.

Name and Title <i>(Please Print)</i>	
Signature	Date