The Georgia Collaborative ASO

GEORGIA COLLABORATIVE ASO
Intellectual & Developmental Disabilities Letter of Intent - Agency

Note: Information must be typed with all fields completed. If a field does not apply, indicate "NA". Handwritten documents will NOT be accepted.

Please return the following checklist and applicable documents to:

Georgia Collaborative Enrollment
P.O. Box 56324
Atlanta, GA 30343

Letter of Intent Checklist:

☐ Certificate of Attendance at the most recent Intellectual & Developmental Disabilities Open Enrollment Forum

☐ Completed Letter of Intent form

☐ Completed Service Location Addendum(s)

☐ Copy of a fully executed contract to verify a minimum of one year of same/similar service delivery during the most recent 12 months

☐ Copy of agency's most recent business Tax Return or audited financial statement

☐ Agency Bank Statements – business statements for previous 6 months

☐ Verification of Tax ID number *(IRS Form 147C or Form CP575A)*

☐ IRS Exempt Letter *(Non-profit applicants only)*

☐ IRS Form 990 *(Non-profit applicants only)*

☐ Three Professional Reference Letters

☐ Copy of "DBA" or trade name Registration *(if applicable)*

☐ Copy of the Current Georgia Secretary of State registration

☐ Copy of County/City Business license or permit for each site or documentation from municipality stating a Business license or permit is not required

☐ Private Home Care (PHC) license

☐ Community Living Arrangement (CLA) Permit
Note: If agency does not currently have required permit (Community Living Arrangement-CLA), if invited, the agency will have 6 months from the date of the Invitation to Apply to submit the CLA permit.

☐ Accreditation Certificate/Award Letter (*if accredited)*

☐ Employment Attestations for:
  - Developmental Disabilities Professional (DDP)
  - Director of Developmental Disabilities Services

☐ Current resume of:
  - Developmental Disabilities Professional (DDP)
  - Director of Developmental Disabilities Services

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I. GENERAL INFORMATION

A. Georgia Agency Information

Agency Legal Name: ____________________

DBA/Trade Name: ____________________

Address: ____________________

City: __________ County: __________ State: ______ Zip Code (9 Digits): __________

Phone #: ____________________ TAX ID#: ____________________

DUNS Number, if applicable: ____________ Fiscal Year End: ____________

Mailing Address (if different): ____________________

City: __________ County: __________ State: ______ Zip Code (9 Digits): __________

B. Executive Leadership/Management

Chief Executive Officer: ____________________

Phone: ____________________ E-mail: ____________________

Agency Contact: ____________________

Phone: ____________________ E-mail: ____________________

Developmental Disabilities Services Director: ____________________

Phone: ____________________ Email: ____________________

Developmental Disabilities Professional (DDP): ____________________

Phone: ____________________ Email: ____________________

Person Completing This Application / Title: ____________________

Phone: ____________________ Email: ____________________

C. Corporate Information

Please complete if agency is part of a corporate system:

Corporate Name: ____________________

Corporate Address: ____________________

City: __________ County: __________ State: ______ Zip Code (9 Digits): __________

Mailing Address *(if different)*: ____________________

City: __________ County: __________ State: ______ Zip Code (9 Digits): __________

D. Business Classification

Please Check only one box for Ownership and only one box for Status.

1. Ownership: ☐ Private ☐ Public ☐ Government Program

2. Status: ☐ For-Profit ☐ Not-for-Profit

E. Accreditation

This organization is accredited by one or more of the following:

☐ Not Accredited

☐ The Joint Commission (TJC)

Certificate No. ____________________ Effective Date:_______________ Expiration Date:______________

☐ Commission on Accreditation of Rehabilitation Facilities (CARF)

Certificate No. ____________________ Effective Date:________________ Expiration Date:______________

☐ Council On Accreditation (COA)

Certificate No. ____________________ Effective Date:________________ Expiration Date:______________

☐ Council on Quality and Leadership (CQL)

Certificate No. ____________________ Effective Date:________________ Expiration Date:______________

☐ Accreditation Commission for Health Care (ACHC) *DD Nursing Only*

Certificate No. ____________________ Effective Date:________________ Expiration Date:______________

☐ Community Health Accreditation Partner (CHAP)

Certificate No. ____________________ Effective Date:________________ Expiration Date:______________

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II. SERVICE LOCATION ADDENDUM

Complete one page per service location.

A. Service Location:

Site Name:____

Address Line 1: ___________________________________

Address Line 2: ___________________________________

City, State, ZIP (9 Digit): ___________________________

Phone Number: ____________________________________

B. Billing Address:
(Please confer with your Billing Dept.)

Address Line 1: ___________________________________

Address Line 2: ___________________________________

City, State, Zip (9 Digit): ___________________________

Phone Number: ____________________________________

C. Counties Requested:

D. Accessibility:
This service location is:

☐ Yes ☐ No - Accessible by Public Transportation

☐ Yes ☐ No - Americans with Disabilities Act Compliant

E. Healthcare Facility Regulation (HFR) Permits/Licenses:
This site is licensed by Healthcare Facility Regulation (HFR) as a (include a copy of the license:)

☐ **Not Applicable**

☐ **Child Caring Institution (CCI)** *Respite Services only*

Certificate No. ___________________ Effective Date:_______________ Expiration Date:______________

☐ **Child Placing Agency (CPA)**

Certificate No. __________________ Effective Date:_______________ Expiration Date:______________

☐ **Community Living Arrangement (CLA)**

Permit No. _______________________ Effective Date:_______________ Capacity:____________________

☐ **Home Health Agency (HHA)**

Certificate No. ____________________ Effective Date:________________ Expiration Date:_______________

☐ **Personal Care Home (PCH)** *Respite Services only*

Permit No. _______________________ Effective Date:_______________ Capacity:____________________

☐ **Private Home Care (PHC)** *Include copy of HFR letter listing counties approved*

Certificate No. ____________________ Effective Date:________________ Expiration Date:_______________

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F. Services Requested Grid

Select the service(s) and applicable waiver being requested.

SERVICES	NOW WAIVER	COMP WAIVER
BEHAVIORAL SUPPORTS CONSULTATION		
BEHAVIORAL SUPPORTS SERVICES		
COMMUNITY ACCESS – GROUP SERVICES		
COMMUNITY ACCESS – GROUP SERVICES – CO-EMPLOYER		
COMMUNITY ACCESS – INDIVIDUAL SERVCES		
COMMUNITY ACCESS – INDIVIDUAL CO-EMPLOYER		
COMMUNITY LIVING SUPPORT SERVICES (CLS) – 15 MINUTES		
COMMUNITY LIVING SUPPORT (CLS) – 15 MINUTES - CO EMPLOYER		
COMMUNITY LIVING SUPPORT SERVICES (CLS) (CLS) – DAILY		
COMMUNITY LIVING SUPPORT SERVICES (CLS) – DAILY CO-EMPLOYER		
COMMUNITY RESIDENTIAL ALTERNATIVE SERVICES (CRA) IN A CLA		
ENVIRONMENTAL ACCESSIBILITY ADAPTATION		
NATURAL SUPPORT TRAINING SERVICE		
NUTRITION SERVICES • EVALUATION • FOLLOW UP		
PREVOCATIONAL SERVICES		
RESPITE SERVICES IN HOME ***(Requires PHC license and must also apply and be approved for CLS)***		
RESPITE SERVICES OUT OF HOME ***(Requires CLA license and must also apply and be approved for CRA. Cannot be provided at a site approved for CRA)***		
SKILLED NURSING SERVICES – REGISTERED NURSE (RN)		
SKILLED NURSING SERVICES – LICENSED PRACTICAL NURSE (LPN)		
SPECIALIZED MEDICAL SUPPLIES		
SPECIALIZED MEDICAL EQUIPMENT		
SUPPORT COORDINATION		
SUPPORTED EMPLOYMENT SERVICES -- GROUP		
SUPPORT EMPLOYMENT SERVICES -- GROUP - CO-EMPLOYER		
SUPPORTED EMPLOYMENT SERVICES – INDIVIDUAL		

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SERVICES	NOW WAIVER	COMP WAIVER
SUPPORTED EMPLOYMENT SERVICES – INDIVIDUAL - CO-EMPLOYER		
TRANSPORTATION – ENCOUNTER/TRIP		
TRANSPORTATION – ENCOUNTER/TRIP - CO-EMPLOYER		
TRANPORTATION – COMMERCIAL CARRIER - MULTI-PASS		
VEHICLE ADAPTATIONS		
OCCUPATIONAL THERAPY (OT) • EVALUATION • THERAPEUTIC ACTIVITIES • SENSORY INTEGRATIVE TECHNIQUES		
PHYSICAL THERAPY (PT) • EVALUATION • THERAPEUTIC PROCEDURES		
SPEECH & LANGUAGE THERAPY • EVALUATION • THERAPY • SPEECH-GENERATING DEVICE THERAPY		

Attestation Statement:
My signature below indicates that all of the information provided above, and in any attachments to this application document, is complete and correct to the best of my knowledge.

Name: ______________________________ Title: ______________________________

Signature: ______________________________ Date: ______________________________

III. PROVIDER PROFILE QUESTIONS

PLEASE ATTACH A DETAILED EXPLANATION FOR ANY QUESTIONS BELOW THAT WERE ANSWERED "YES"

Please answer the following questions regarding your organization's programs:

1. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had its professional liability or malpractice insurance refused, revoked, declined or accepted on special terms in the past five (5) years? ☐ Yes ☐ No

2. Has any government agency suspended, revoked, or taken other action against the organization's license to practice or to conduct business in the past five years, or taken such an action in the past five years against any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee? (To include Medicaid /Medicare) ☐ Yes ☐ No

3. Have any accreditations or memberships in professional organizations been revoked, reduced, denied, or suspended by others or voluntarily given up by the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, in the last five years, or are any actions now under way which may lead to such sanctions? ☐ Yes ☐ No

4. Has any Owner, Managing Employee, officer, or shareholder of the organization **ever** been convicted of a crime, excluding minor traffic misdemeanors? ☐ Yes ☐ No

5. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, **ever** been previously denied acceptance into, disenrolled from, or withdrawn from GA DBHDD or GA Collaborative ASO network participation? ☐ Yes ☐ No

6. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had any settled claims or judgments relating to sexual misconduct or civil rights violations in the past five years? If **Yes**, enter the total number: _______ ☐ Yes ☐ No

7. In the past five years, has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had any settled claims or judgments relating to any other matter not disclosed in the response to Question 6 above? If **Yes**, enter the total number:_______ ☐ Yes ☐ No

8. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, been a defendant in five (5) or more lawsuits within the **past five (5) years?** If **Yes**, enter the total number: _______ ☐ Yes ☐ No

9. Does the organization hire, continue to employ, or contract with individuals listed on the Office of Inspector General's List of Excluded Individuals/Entities (to include owners, officers, employees, subcontractors, and others identified in §1128)? ☐ Yes ☐ No

10. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, filed for Bankruptcy in the past five years? ☐ Yes ☐ No

IV. Employment Attestation: Director of Developmental Disabilities Services

The minimum responsibilities of the Director are specified below. My signature indicates that I have read these responsibilities, discussed them with (agency representative or Owner or CEO)

____

Name of Agency Representative or Owner or CEO

I agree that I will be employed by this agency and accountable for meeting each of these requirements. I also agree that I have reviewed my resume submitted by this agency and agree that it accurately reflects both my education and experience.

Duties of the Director for Disabilities Services include, but are not limited to:

- Overseeing the day-to-day operation of the agency;
- Managing the use of agency funds;
- Ensuring the development and updating of required policies of the agency;
- Managing the employment of staff and professional contracts for the agency;
- Designating another agency staff member to oversee the agency in my absence.

_______________________ _______________________

Signature **Date**

____

Printed Name

V. Employment Attestation: Developmental Disabilities Professional (DDP)

The minimum responsibilities of the agency's DDP are specified below. My signature indicates that I have read these responsibilities, discussed them with (agency representative or Owner or CEO)

____

Name of Agency Representative or Owner or CEO

I agree I will be employed by this agency and accountable for meeting each of these requirements. I also agree that I have reviewed my resume submitted by this agency and agree that it accurately reflects both my education and experience.

At least one agency employee or professional under contract with the agency must be a Developmental Disability Professional (DDP) (for definition, see *Part II Policies and Procedures for COMP*, *Appendix I);*

Duties of the DDP include, but are not limited to:

- Overseeing the services and supports provided to participants;
- Supervising the formulation of the participant's plan for delivery of all waiver services provided to the participants by the provider;
- Conducting functional assessments; and
- Supervising high intensity services.

______________________________ ______________________________

Signature **Date**

____

Printed Name

VI. PARTICIPATION STATEMENT:

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) requires that services be provided according to the service guidelines and that the agency will operate in accordance with applicable standards, rules and regulations and policies.

By signing below, I hereby certify and attest that my staff, agents, contractors, subcontractors, billing agent(s) and I have reviewed and agree to comply with the terms and conditions set forth in the applicable DBHDD and Department of Community Health (DCH)/ Medicaid Provider manuals.

I understand and acknowledge that the policies and procedures manuals are amended (generally on a quarterly basis) when either Department finds it necessary or appropriate to do so, and that it is my responsibility to check periodically for any revisions pertaining to the delivery of or reimbursement for services rendered to eligible individuals.

I further understand that failure to abide by either Department's (DBHDD or DCH) policies and procedures will result in adverse actions including, but not limited to the denial of claims, monetary recoupment, termination, suspension of payments, and reduction of reimbursement.

I certify and attest that I have reviewed the entire contents of the completed application and that the information provided is accurate and complete. I understand that inaccurate, incomplete or omitted data may lead to sanctions against me.

Under applicable state and federal laws, I do hereby affirm that I am the authorized agent to complete this document and that the information contained herein this document is complete, true, and correct to the best of my knowledge. I understand that material misrepresentation and/or falsification of any information contained herein shall result in the immediate removal of further consideration for participation.

____
Agency Name

____ **Date (mm/dd/yy): _____/______/______**
Authorized Signature

____
Name (Please Print)

____
Title