

New Agency Provider Application Developmental Disabilities

Agency: _____

This application is to be completed upon notification of your Letter of Intent approval. 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

OR

Email to: GA_Enrollment@beaconhealthoptions.com

New Agency Provider Application Checklist:

- Completed New Provider Application Checklist
- Completed Application
- Application Invitation Letter
- Completed Service Location Addendum
- Copy of current Commercial General Liability or Comprehensive General Liability insurance certificate
- Agency Line of Credit – \$50,000 per residential site if applying for Community Residential Alternative (CRA) services

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Details for Application Requirements	
Copy of Application Invitation Letter	Provide a copy of the Application Invitation Letter received after successful completion of the Letter of Intent phase.
Commercial General Liability Insurance	<p>DBHDD requires providers to submit a certificate of insurance demonstrating the following types of insurance coverage:</p> <ul style="list-style-type: none"> A. <u>Commercial General Liability Policy:</u> The Commercial General Liability Policy shall have dollar limits of \$1,000,000 per incident and an annual aggregate limit of \$3,000,000.00. B. <u>Business Auto Policy:</u> The Business Auto Policy shall include but not be limited to liability coverage on any owned, non-owned and hired vehicle used by Provider or Provider’s personnel in the performance of services approved by DBHDD. C. <u>Workers Compensation Insurance:</u> The Workers Compensation Policy shall include coverage in the amounts of the statutory limits established by the General Assembly of the State of Georgia O.C.G.A. Section 33-9-40.1. D. <u>Commercial Umbrella Policy:</u> The Commercial Umbrella Policy must provide the same or broader coverage than those provided for in the above Commercial General Liability and Business Auto Policies. <p>Each service location must be listed on the certificate. The certificate holder listed on the insurance certificate must be:</p> <p style="text-align: center;"> The State of Georgia Department of Behavioral Health & Developmental Disabilities Office of Provider Enrollment 2 Peachtree Street NW, Suite 23-247 Atlanta, GA 30303 </p>

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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#: _____

Mailing Address (if different): _____

City: _____ County: _____ State: _____ Zip Code (9 Digits): _____

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. Counties Requested:

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C. Accessibility:

This service location is:

Yes No - Accessible by Public Transportation Yes No - Americans with Disabilities Act Compliant

D. 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)

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)

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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E. Services Requested Grid

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

SERVICES: (THE SERVICES SELECTED SHOULD BE ONLY THE SERVICES APPROVED IN YOUR INVITATION LETTER. NO NEW SERVICES CAN BE ADDED)	NOW WAIVER	COMP WAIVER
BEHAVIORAL SUPPORTS SERVICES <ul style="list-style-type: none"> • LEVEL I • LEVEL II 		
ADULT NUTRITION SERVICES		
ADULT OCCUPATIONAL THERAPY (OT)		
ADULT PHYSICAL THERAPY (PT)		
ADULT SPEECH/LANGUAGE THERAPY (SLT)		
COMMUNITY ACCESS – GROUP SERVICES		
COMMUNITY ACCESS – GROUP SERVICES – CO-EMPLOYER		
COMMUNITY ACCESS – INDIVIDUAL SERVICES		
COMMUNITY ACCESS – INDIVIDUAL CO-EMPLOYER		
COMMUNITY LIVING SUPPORT SERVICES (CLS)		
COMMUNITY LIVING SUPPORT SERVICES – CO-EMPLOYER		
COMMUNITY RESIDENTIAL ALTERNATIVE SERVICES (CRA) IN A CLA		
ENVIRONMENTAL ACCESSIBILITY ADAPTATION		
NATURAL SUPPORT TRAINING SERVICE		
NURSING SERVICES – REGISTERED NURSE (RN)		
NURSING SERVICES – LICENSED PRACTICAL NURSE (LPN)		
PREVOCATIONAL SERVICES		
RESPIRE SERVICES IN HOME <i>(Requires PHC license and must also apply and be approved for CLS)</i>		
RESPIRE SERVICES OUT OF HOME <i>(Requires a Child Caring Institute, CLA or PCH Permit. Agency must also apply and/or already be approved for CRA services. Cannot be provided at a site approved for CRA)</i>		
RESPIRE SERVICES – CO-EMPLOYER		
SPECIALIZED MEDICAL EQUIPMENT		
SPECIALIZED MEDICAL SUPPLIES		
SUPPORTED EMPLOYMENT SERVICES – GROUP		

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SUPPORTED EMPLOYMENT SERVICES – GROUP - CO-EMPLOYER		
SUPPORTED EMPLOYMENT SERVICES – INDIVIDUAL		
SUPPORTED EMPLOYMENT SERVICES – INDIVIDUAL - CO-EMPLOYER		
TRANSPORTATION – ENCOUNTER/TRIP		
TRANSPORTATION – ENCOUNTER/TRIP - CO-EMPLOYER		
TRANSPORTATION – COMMERCIAL CARRIER - MULTI-PASS		
VEHICLE ADAPTATIONS		

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: _____

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IV. 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

Authorized Signature

Date (mm/dd/yy): ____/____/____

Name (Please Print)

Title