The Georgia Collaborative ASO

DEVELOPMENTAL DISABILITIES INDIVIDUAL LETTER OF INTENT

To ensure timely processing of your application, please return the following checklist completed Letter of Intent (LOI) and documents requested to:

Georgia Collaborative
Enrollment PO Box 56324
Atlanta, Georgia 30343

Checklist:

☐ Certificate of Attendance at the most recent DD Provider Forum

☐ Completed and signed Individual Provider Letter of Intent Application

☐ Current State License/Certification, if applicable (NOTE: LPN's must also submit the license and the agreement with the RN providing required supervision)

☐ Proof of Board Certification, if applicable

☐ Copy or Verification of High School Diploma or GED (If not licensed)

☐ For Behavioral Support Consultant applicants only: Copy of transcript for documentation of required education and/or hours of training as noted in the service definition

☐ Work History/ Curriculum Vitae/Resume (**must include month and year**) Any lapse in continuous employment/ work history within the past 5 years must be fully explained on a separate sheet.

☐ Proof of One Year Experience (**For any service not listed as a professionally licensed required service, include documentation that specifies the individual provided the waiver service for at least one year through NOW/ COMP self-direction prior to submission of the application.)**

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1. PROVIDER INFORMATION (* indicates required fields)

A. DEMOGRAPHIC INFORMATION

Last Name*		First Name*			Middle Initial	☐Male ☐Female
Mailing Address Line 1*		Mailing Address Line 2*				
City*	County*	State*	Zip (9 digit)*	Telephone #: (Include area code)		
Social Security Number *	Date of Birth *	Professional Designation or Title*				
U.S. Citizen: ☐ Yes ☐ No	E-mail address:		Website if applicable:			
Indicate any other name you may have used in the past* (e.g., maiden name, etc).						

B. ALTERNATE COMMUNICATION METHOD: Please enter your alternate method of communication. If you only have one preferred method, please indicate N/A on the other method.

METHOD	(Note any changes here if different from above)
Fax #:	
E-mail Address:	

2. REFERRAL INFORMATION

A. LICENSED DISCIPLINE: If LICENSED or CERTIFIED, indicate the discipline under which you are LICENSED and/or CERTIFIED at the highest level to practice independently.

☐ Behavioral Analyst	☐ Registered Nurse
☐ Registered/ Licensed Dietitian	☐ Licensed Practical Nurse
☐ Licensed Occupational Therapist	☐ Other (specify):

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☐ Licensed Physical Therapist ☐ Licensed Speech and Language Pathologist	☐ Not Applicable ___________________________

B. LANGUAGE

Identify any foreign language(s) or sign language that you use fluently (select no more than 5):

☐ American Sign Language (SG)	☐ Dutch (DU)	☐ Hungarian (HU)	☐ Portuguese (PO)	☐ Other (OT):
☐ Armenian (AN)	☐ French (FR)	☐ Italian (IT)	☐ Russian (RU)	
☐ Arabic (AR)	☐ German (GE)	☐ Korean (KO)	☐ Spanish (SP)	
☐ Braille	☐ Greek (GR)	☐ Mandarin	☐ Tagalog/Filipino (PH)	
☐ Chinese (CH)	☐ Hebrew (HE)	☐ Norwegian (NW)	☐ Vietnamese (VI)	
☐ Creole/Haitian	☐ Hindi (HI)	☐ Polish (PL)	☐ Yiddish (YI)	

3. LOCATION INFORMATION

A. LOCATION INFORMATION (IF SERVICES ARE DELIVERED IN ANY LOCATION OTHER THAN THE INDIVIDUAL PARTICIPANT'S HOME, THE INDIVDUAL PROVIDER'S DELIVERY SITE MUST BE HANDICAP ACCESSIBLE.

Site Name:			Appointment Telephone (include area code)
Address Line 1 (street address required for referral purposes)		Address Line 2	
City	County	State	Zip (9 digit)

4. EDUCATION INFORMATION (REQUIRED for verification purposes)

Educational Institution (include name and complete address)			Degree/ Certification	From (mm/yy)	To (mm/yy)
High School	Institution:		N/A		
	Address:				
	City, State, Zip				
Undergraduate	Institution:				
	Address:				

	City, State, Zip:				
Major/Minor:					
Graduate	Institution:				
	Address:				
	City, State, Zip:				
Major/Minor:					
Internship	Institution:				
	Address:				
	City, State, Zip:				
Field:					

5. LICENSE/CERTIFICATION INFORMATION

A. PROFESSIONAL LICENSE(S)/ CERTIFICATES: Please identify in the list below, **all** health care licenses/certificates held in the past ten (10) years. Indicate original licensure date through current expiration date for each state in which you are or have been licensed/certified. Please provide an explanation for any license/certificate that is no longer current, whether by voluntary relinquishment or disciplinary or other action. Attach an additional sheet if necessary.

Certifying Authority	State	Specify Active or Inactive	Certificate #	Original Issue Date (mm/dd/yy)	Expiration Date (mm/dd/yy)

Please include a current copy of your certification with your application materials.

6. WORK HISTORY

A. WORK HISTORY

This section may be used to provide your work history. A current Curriculum Vitae or Resume (**must specify month and year**) may be submitted in lieu of completing this section. **Any lapse in continuous employment within past 5 years of graduate degree program must be fully explained on a separate sheet (attached).**

From (Month/Year) required	To (Month/Year)	Place of Employment / Description of Activities

7. WAIVER SERVICE INFORMATION

A. Please indicate which waiver service(s) you are requesting as well as the Category of Service.

SERVICES	NOW WAIVER	COMP WAIVER
BEHAVIORAL SUPPORTS CONSULTATION		
BEHAVIORAL SUPPORTS SERVICES		
COMMUNITY ACCESS – INDIVIDUAL SERVCES		
NUTRITION SERVICES • EVALUATION • FOLLOW UP		
OCCUPATIONAL THERAPY (OT) • EVALUATION • THERAPEUTIC ACTIVITIES • SENSORY INTEGRATIVE TECHNIQUES		
PHYSICAL THERAPY (PT) • EVALUATION • THERAPEUTIC PROCEDURES		
SPEECH & LANGUAGE THERAPY • EVALUATION • THERAPY • SPEECH-GENERATING DEVICE THERAPY		
SKILLED NURSING SERVICES REGISTERED NURSE (RN)		
SKILLED NURSING SERVICES LICENSED PRACTICAL NURSE (LPN)		

B. COUNTIES REQUESTED: Please indicate Counties Requested

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INDIVIDUAL PROVIDER PROFILE

Please answer all provider profile questions.

In answering the questions listed below, if you answer YES, please provide documentation describing the circumstances surrounding the events, settlements, and or resolutions of the issues in the State of Georgia or in any other state.

1. Have you had your 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 your license to practice or to conduct business in the past five years, (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 you in the last five years, or are any actions now under way which may lead to such sanctions? ☐ Yes ☐ No

4. Have you ever been convicted of a crime, excluding minor traffic misdemeanors? ☐ Yes ☐ No

5. Have you **ever** been previously denied acceptance into, disenrolled from, or withdrawn from GA DBHDD or GA Collaborative ASO network participation? ☐ Yes ☐ No

6. Have you 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, have you 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. Have you been a defendant in five (5) or more lawsuits within the **past five (5) years?**
   If **Yes**, enter the total number: _____ ☐ Yes ☐ No

9. Have you filed for Bankruptcy in the past five years? ☐ Yes ☐ No

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ATTESTATION/PARTICIPATION STATEMENT

Developmental Disabilities Services:

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

By signing below, I do hereby certify that I have accessed, reviewed and agree to comply with the terms and conditions set forth in the following:

- Provider Manual for Community Developmental Disabilities Providers
- Criminal History Record Check for Contractors, 04-104
- Rules and Regulations of Department of Behavioral Health and Developmental Disabilities - Client's Rights (Chapter 290-4-9)
- Department of Community Health (DCH) Policies and Procedures Manuals, found at the following links:
  - Part I Policies and Procedures / Billing Manual
  - Part II– Policies and Procedures for COMPREHENSIVE SUPPORTS WAIVER PROGRAM (COMP) and NEW OPTIONS WAIVER PROGRAM (NOW)
  - Part III– Policies and Procedures for COMPREHENSIVE SUPPORTS WAIVER PROGRAM (COMP)
  - Part III– Policies and Procedures for NEW OPTIONS WAIVER PROGRAM (NOW)

I understand and acknowledge that the policies and procedures manuals are amended 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 policies or procedures will result in adverse actions including, but not limited to the denial of claims, monetary recoupment, suspension of payments, suspension of referrals, reduction of reimbursement and termination.
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.

____
Name of Individual (please print)

____
Signature of Individual

____
Date