**APPLICATION TO PROVIDE DDDS HOME AND COMMUNITY-BASED (HCBS) SERVICES**

**LIFESPAN WAIVER AND PATHWAYS**

# APPLICANT GENERAL INFORMATION:

The DELAWARE DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES (DDDS) accepts applications to provide DDDS Waiver HCBS services on an open and continuous basis. Providers may apply to provide services under the Lifespan Waiver and/or the Pathways State Plan Amendment (SPA) authorities. Providers that DDDS determines to be qualified must contract with DDDS in addition to their contract with the State Medicaid Agency.

Submit this completed application and all REQUIRED SUPPORTING DOCUMENTATION to:

 DDDS\_ProviderAuthCommittee@delaware.gov.

The subject line must be in the following format: <Company Name, Service applying for>

* 1. **CONTACT INFORMATION**

Application Date: Click or tap to enter a date.

Name of Individual/Organization:

Current Street Address:

City:

State:       Zip Code:

Primary Contact Name:

Primary Phone Number:

Primary E-mail Address:

Alternate Contact Name:

Alternate Phone Number:

Alternate E-mail Address:

Website Address (if applicable):

National Provider ID:

Tax ID Number:

* 1. **SERVICES TO BE PROVIDED VIA LIFESPAN WAIVER:** *(Check all that apply and select one provider type for each service for which you are applying)*

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| **[ ]  DAY SERVICES – DAY HABILITATION** |
|  Provider type (select one):[ ]  DAY HABILITATION AGENCY |
| **[ ]  DAY SERVICES – COMMUNITY PARTICIPATION** |
|  Provider type (select one):[ ]  DAY HABILITATION AGENCY |
| **[ ]  PERSONAL CARE** |
|  Provider type (select one):**[ ]** PERSONAL ASSISTANCE SERVICE AGENCY (PASA)[ ]  HOME HEALTH AGENCY |
|  **[ ]  DAY SERVICES – PREVOCATIONAL SERVICES** |
|  Provider type (select one):[ ]  PREVOCATIONAL SERVICES AGENCY |
|  **[ ]  RESIDENTIAL HABILITATION** |
|  Provider type (select one):  [ ]  RESIDENTIAL HABILITATION AGENCY  |
| **[ ]  RESPITE** |
|  Provider type (select one): [ ]  PUBLIC ICF/IID [ ]  PERSONAL ASSISTANCE SERVICE AGENCY (PASA) [ ]  SHARED LIVING PROVIDER [ ]  HOME HEALTH AGENCY [ ]  RESIDENTIAL HABILITATION AGENCY |
|  **[ ]  DAY SERVICES – INDIVIDUAL SUPPORTED EMPLOYMENT** |
|  Provider type (select one):[ ]  SUPPORTED EMPLOYMENT AGENCY |
|  **[ ]  DAY SERVICES – (SMALL) GROUP SUPPORTED EMPLOYMENT** |
|  Provider type (select one):[ ]  SUPPORTED EMPLOYMENT AGENCY |
| **[ ]  ASSISTIVE TECHNOLOGY (SERVICES OR EQUIPMENT)** |
|  Provider type (select one): [ ]  LICENCED/CERTIFIED PROFESSIONAL - AGENCY[ ]  LICENCED/CERTIFIED PROFESSIONAL - INDIVIDUAL[ ]  ASSISTIVE TECHNOLOGY SUPPLIER |
| **[ ]  BEHAVIORAL CONSULTATION**  |
|  Provider type (select one): [ ]  BEHAVIORAL CONSULTATION AGENCY |
| **[ ]  COMMUNITY TRANSITION** |
|  Provider type (select one): [ ]  RESIDENTIAL HABILITATION PROVIDER[ ]  COMMUNITY TRANSITION PROVIDER |
| [ ]  **HOME MODIFICATION** **[ ]  VEHICLE MODIFICATION** |
|  Provider type (select one): [ ]  LICENSED CONTRACTOR- AGENCY[ ]  VENDOR – VEHICLE MODIFICATIONS[ ]  LICENSED CONTRACTOR- INDIVIDUAL  |
|  **[ ]  NURSE CONSULTATION**  |
|  Provider type (select one): [ ]  NURSE CONSULTATION AGENCY |
| [ ]  **SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES (not otherwise covered by Medicaid)** |
|  Provider type (select one): [ ]  DURABLE MEDICAL EQUIPMENT SUPPLIER |
| [ ]  **SUPPORTED LIVING** |
|  Provider type (select one): [ ]  RESIDENTIAL HABILITATION AGENCY[ ]  SUPPORTED LIVING PROVIDER |

* 1. **SERVICES TO BE PROVIDED VIA PATHWAYS:** *(Check all that apply and select one provider type for each service for which you are applying)*

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| **[ ]  CAREER EXPLORATION AND ASSESSMENT** |
|  Provider type (select one): [ ]  CAREER EXPLORATION AGENCY |
| **[ ]  SUPPORTED EMPLOYMENT - INDIVIDUAL** |
|  Provider type (select one): [ ]  SUPPORTED EMPLOYMENT AGENCY |
| **[ ]  SUPPORTED EMPLOYMENT – SMALL GROUP** |
|  Provider type (select one): [ ]  SUPPORTED EMPLOYMENT AGENCY |
| **[ ]  BENEFITS COUNSELING** |
|  Provider type (select one): [ ]  BENEFITS COUNSELING AGENCY |
| **[ ]  FINANCIAL COACHING PLUS** |
|  Provider type (select one): [ ]  FINANCIAL COACHING AGENCY |
| **[ ]  PERSONAL CARE** |
|  Provider type (select one): [ ]  HOME HEALTH AGENCY[ ]  PERSONAL ASSISTANCE SERVICE AGENCY (PASA)[ ]  PERSONAL ATTENDANT |
|  **[ ]  ORIENTATION AND MOBILITY** **[ ]  ASSISTIVE TECHNOLOGY**  |
|  Provider type (select one): [ ]  CERTIFIED ORIENTATION AND MOBILITY SPECIALIST[ ]  CERTIFIED VISION REHABILITATION THERAPIST[ ]  OCCUPATIONAL THERAPIST[ ]  ASSISTIVE TECHNOLOGY PROFESSIONAL[ ]  LOW VISION THERAPIST[ ]  DURABLE MEDICAL EQUIPMENT SUPPLIER[ ]  ASSISTIVE TECHNOLOGY SUPPLIER |

**NOTE: Providers may apply to provide any of the following services under either or both authorities. Exercise caution to ensure familiarity with scope and eligibility criteria for each authority.**

* **Supported Employment – Individual**
* **Supported Employment – Group**
* **Personal Care**
* **Assistive Technology**
1. **APPLICATION PREPARATION:** *(check one)*

**[ ]** Agency staff (including subsidiary staff) prepared this application.

OR

[ ]  A contracted or other non-agency entity prepared this application. My signature below attests that I have read and agree with all contents of this application, and that I understand that DDDS may review this application for verbatim narratives with other applications or documents.

# ATTESTATION:

I hereby certify the information provided in this application is true and complete. I am aware that should an investigation at any time disclose any misrepresentation or falsification of information, my application may be rejected and/or my DDDS provider authorization revoked. I also attest that I have reviewed and will comply with the DDDS Provider Standards and the Home and Community Based Services Settings Rule.

|  |  |
| --- | --- |
| **DATE:** |       |
| **PRINT PROVIDER REPRESENTATIVE NAME AND TITLE:** |       |
| **SIGNATURE:** |       |

NOTE: DDDS will only review complete application packages. DDDS will reject incomplete application packages.