



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

I. 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 that are deemed qualified by DDDS may also be required to enter into a contract with DDDS in addition to the contract with the State Medicaid Agency.

Please submit this completed application and all REQUIRED SUPPORTING DOCUMENTATION to:
DDDS_ProviderAuthCommittee@delaware.gov

A. CONTACT INFORMATION

Application Date:

Name of Individual/Organization:

Current Street Address:

City:

State:

Zip Code:

Primary Contact: First Name:

Last Name:

Primary Phone Number:

Primary E-mail Address:

Alternate Contact: First Name:

Last Name:

Alternate Phone Number:

Alternate E-mail Address:

Website Address (if applicable):

National Provider ID:

Tax ID Number:



B. SERVICES TO BE PROVIDED: *(Check all that apply)*

<input type="checkbox"/> ASSISTIVE TECHNOLOGY (SERVICES OR EQUIPMENT)	
<input type="checkbox"/> LICENCED/CERTIFIED PROFESSIONALS - AGENCY	<input type="checkbox"/> LICENCED/CERTIFIED PROFESSIONALS - INDIVIDUAL
<input type="checkbox"/> DURABLE MEDICAL EQUIPMENT SUPPLIER	<input type="checkbox"/> NON-TRADITIONAL OFF-THE-SHELF SUPPLIER
<input type="checkbox"/> CLINICAL CONSULTATION	
<input type="checkbox"/> BEHAVIORAL	<input type="checkbox"/> NURSING
<input type="checkbox"/> COMMUNITY TRANSITION	
<input type="checkbox"/> RESIDENTIAL HABILITATION PROVIDER	<input type="checkbox"/> OTHER COMMUNITY TRANSITION PROVIDER
<input type="checkbox"/> DAY SERVICES	
<input type="checkbox"/> INDIVIDUAL SUPPORTED EMPLOYMENT	<input type="checkbox"/> SMALL GROUP SUPPORTED EMPLOYMENT
<input type="checkbox"/> COMMUNITY PARTICIPATION	<input type="checkbox"/> DAY HABILITATION
<input type="checkbox"/> PREVOCATIONAL SERVICES	
<input type="checkbox"/> HOME MODIFICATION	<input type="checkbox"/> VEHICLE MODIFICATION
<input type="checkbox"/> LICENSED CONTRACTOR- INDIVIDUAL	<input type="checkbox"/> LICENSED CONTRACTOR- AGENCY
<input type="checkbox"/> OTHER VENDOR	
<input type="checkbox"/> PERSONAL CARE	
<input type="checkbox"/> PERSONAL ASSISTANCE SERVICE AGENCY (PASA)	<input type="checkbox"/> HOME HEALTH AGENCY
<input type="checkbox"/> RESIDENTIAL HABILITATION	
<input type="checkbox"/> RESIDENTIAL HABILITATION AGENCY <i>(you must also check "Community Transition" above)</i>	
<input type="checkbox"/> RESPITE	
<input type="checkbox"/> PERSONAL ASSISTANCE SERVICE AGENCY (PASA)	<input type="checkbox"/> HOME HEALTH AGENCY
<input type="checkbox"/> RESIDENTIAL HABILITATION AGENCY	<input type="checkbox"/> PUBLIC ICF/IID
<input type="checkbox"/> SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES (not otherwise covered by Medicaid)	
<input type="checkbox"/> DURABLE MEDICAL EQUIPMENT SUPPLIER	
<input type="checkbox"/> SUPPORTED LIVING	
<input type="checkbox"/> RESIDENTIAL HABILITATION AGENCY	



II. 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 which include all of the elements to comply with the Home and Community Based Services Settings Rule.

DATE:	
PRINT PROVIDER REPRESENTATIVE NAME AND TITLE:	
SIGNATURE:	

Please note: Applications received without the requested supporting documentation will be considered incomplete and will be returned to the submitting entity.
 Only complete application packages will be reviewed by DDDS.