PROVIDER AUTHORIZATION COMMITTEE

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 Provider Authorization Committee - Fox Run Professional Center
2540 Wrangle Hill Road, Suite 100
Bear, DE 19701

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*

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