PROVIDER QUALIFICATION INSTRUCTIONS

**APPLICATION TO PROVIDE NON-RECURRING DDDS HCBS SERVICES**

SEE THE “APPLICATION TO PROVIDE DDDS HCBS SERVICES FOR THE FOLLOWING SERVICES:

► Day Habilitation ► Community Participation

► Personal Care ► Prevocational Services

► Residential Habilitation ► Respite

► Supported Employment (Individual) ► Supported Employment (Group)

► Behavior Consultation ► Nurse Consultation

► Supported Living ► Career Exploration and Assessment

► Benefits Counseling ► Financial Coaching Plus

**If you are applying to become an Authorized Provider of Residential Habilitation services AND you are simultaneously applying to provide Community Transition services…. Check here**  **and submit Section 4 ONLY.**

1. **INTRODUCTION**

The Division of Developmental Services (DDDS) seeks to provide a robust network of quality providers to deliver services and supports available under the DDDS Medicaid Home and Community-based Services (HCBS) Lifespan Waiver and the Pathways State Plan Amendment. DDDS accepts applications on an open and continuous basis as required by Medicaid regulations.

DDDS must approve an entity’s application prior to it providing an HCBS service(s). Entities seeking DDDS approval must submit the following completed documents to DDDS:

* Application to Provide DDDS HCBS Services (hereafter referred to as the “provider application”)
* Requirements Summary Checklist
* Application narrative sections

If you are applying to become an Authorized Provider of Residential Habilitation services AND you are simultaneously applying to provide Community Transition services, you must submit the following documents to DDDS:

* Application to Provide DDDS HCBS Services (hereafter referred to as the “provider application”)
* Requirements Summary Checklist
* Application narrative sections
* Requirements Summary Checklist Non-Recurring Services for Community Transition
* Application narrative section #4 from Provider Qualification Instructions Non-Recurring Services

The written proposal must include all information and supporting documentation. Appendix A displays a checklist of all documents that DDDS requires for a complete application. The applicant must submit each response as a separate .pdf document. DDDS will return incomplete applications to the submitting agency. All documents submitted with the application become the property of DDDS. Applicants should retain a copy of all documents they submit to DDDS.

Completion of the provider application does not guarantee DDDS approval. Approval of a provider to deliver DDDS HCBS services does not guarantee that waiver members will select the provider. Per Medicaid requirements, HCBS waiver members have the right to choose their providers.

If approved, providers must enroll with the Medicaid agency to provide DDDS HCBS waiver services. Approval by DDDS is a prerequisite to enroll with the Medicaid agency to deliver most DDDS HCBS services. The Medicaid agency will ask for the DDDS qualification letter during the enrollment process. Providers of DDDS HCBS services will be required to sign contracts with both the Medicaid agency and with DDDS.

During the application process DDDS staff may provide information about the provider qualification process and waiver services but may not provide legal, technical, financial, or other business information.

1. **DOCUMENTATION REQUIREMENTS**

Applicants must answer ALL QUESTIONS and clearly cite the question number in its application narrative. The applicant must submit a Requirements Summary Checklist (see Appendix A) that includes each question number and the page number(s) on which DDDS can find the response to that question. The applicant must answer the questions in the order found in the application. DDDS encourages both thoroughness and conciseness in applications. If a question does not apply the applicant must include a response to the question by responding “N/A” and including the reason the question is not applicable. Do not leave any questions unanswered. DDDS will return incomplete applications.

Members of the Authorized Provider Committee score applications by assigning a maximum of 100 points across four (4) criteria: 100/100

1. Programs and Services 30/30
2. Service Integrity 20/20
3. Business Practices 20/20
4. Service Description 30/30

The Service Description section contains separate sections for Lifespan Waiver services and for Pathways services. A provider may request approval for assistive technology services across both authorities using a single application.

DDDS will deny applications that receive an average score of less than 80 points. If the Authorized Provider Committee determines the interested applicant is not eligible, DDDS will send a denial letter that includes the reason(s) for denial. The provider may submit a new/revised application after six (6) months from the date of the denial letter.

DDDS will schedule interviews with agencies whose applications score 80 points or more. The Authorized Provider Committee will score the interview by assigning a maximum of 100 points. DDDS reserves the right to reject any application that scores 0 points on any question or sub-question or on any component of the interview.

**NOTE:** The “Label” conventions used below correspond to the label conventions used in the Requirements Summary Checklist. If you are applying to provide ONLY non-recurring services, you must still use the Label conventions shown below.

**INSTRUCTIONS FOR APPLICATION NARRATIVE**

1. **PROGRAMS AND SERVICES – ALL SERVICES (30 points)**

Describe your agency or company. The description should include the following:

A1 Describe the services your agency or company provides and the process by which you provide the service.

A3 Describe any professional or business associations to which you belong (ex: Better Business Bureau, etc.).

A7 Provide two (2) letters of reference that attest to the quality of the service you propose to provide. The letters must be signed, dated within the past 12 months, and printed on the letterhead of the reference (unless it is a reference from an individual).

1. **SERVICE INTEGRITY – ALL SERVICES (20 points)**

B7 Describe your customer service program.

B8 Provide an example of exceptional customer service.

1. **BUSINESS PRACTICES – ALL SERVICES (20 points)**

C1 Describe the legal structure of your business (ex: sole proprietorship, LLC, general or limited partnership, 501(c)(3), etc.).

C7 Submit a copy of the agency’s current Delaware business license or 501(c)(3) documentation.

1. **SERVICE DESCRIPTION – LIFESPAN WAIVER SERVICES (30 points)**

Submit a detailed description of the service for which the agency is requesting approval. The service descriptions must match the services included in Section IB of the on the Provider Application. The agency must explain in detail how it will fulfill the service requirements contained in Appendix C of Delaware’s latest approved Application for the 1915 (c) Home and Community-Based Services Waiver. Each application must also include the following information based on the service for which the agency is applying.

**ASSISTIVE TECHNOLOGY (NOT OTHERWISE COVERED BY MEDICAID)**

U1 – Explain how the agency evaluates the assistive technology needs of waiver participants.

U2 – Explain how the agency ensures assistive technology is not covered by other payor sources.

U3 – Explain how the agency ensures that the waiver member will gain maximum benefit from the assistive technology equipment (training on use of equipment, maintaining equipment, customizing equipment, etc.).

U4 – Provide evidence of: Occupational Therapists, Physical Therapists or Speech Pathologists licensed by the Delaware Division of Professional Regulation under Title 24 of the Delaware Administrative Code, sections 2000, 2600 and 3700, respectively, if applicable.

U5 – Provide evidence of being certified by ATP RESNA Rehabilitation Engineering and Assistive Technology Society of North America.

**HOME OR VEHICLE ACCESSIBILITY ADAPTATIONS**

V1 – Describe how the agency ensures compliance with applicable building codes and required permits (for home adaptations) and industry standards and codes (for vehicle adaptations).

V2 – Describe the agency’s experience with providing the kinds of home modifications and/or vehicle adaptations that it will be providing under the waiver.

V3 - Describe the specific activities | adaptations the agency is qualified to perform.

V4 - Home-Licensed Contractor (only): Provide evidence of being a licensed contractor to do business within the State of Delaware and that your agency holds applicable certificates, standards, licenses, bonds, and permits required.

V5 – Describe your warranty program (providers must warranty their service for at least one year).

**SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES NOT OTHERWISE COVERED BY MEDICAID**

W1 – Describe the specific categories of specialized equipment and supplies the agency is qualified to provide.

**COMMUNITY TRANSITION**

X1 – Describe how your agency will ensure the service is a one-time support.

X2 - Describe how your agency will ensure that the requested funds will be used only toward allowable expenses.

X3 – Explain how the agency will ensure that waiver funds are the payor of last resort.

1. **SERVICE DESCRIPTION – PATHWAYS SERVICES (30 points)**

Submit a detailed description of the service for which the agency is requesting approval. The service descriptions must match the services included in Section IC of the Provider Application. The agency must explain in detail how it will fulfill the service requirements contained in the “Services” section of Delaware’s latest approved 1915 (i) State Plan Amendment. Each application must also include the following information based on the service for which the agency is applying.

**ORIENTATION AND MOBILITY**

Y1 – Explain how the agency ensures that the waiver member will gain maximum benefit from orientation and mobility services.

Y2 – Describe how the agency tailors service delivery to each individual’s needs.

**ASSISTIVE TECHNOLOGY (NOT OTHERWISE COVERED BY MEDICAID)**

U1 – Explain how the agency evaluates the assistive technology needs of waiver participants.

U2 – Explain how the agency ensures assistive technology is not covered by other payor sources.

U3 – Explain how the agency ensures that the waiver member will gain maximum benefit from the assistive technology equipment (training on use of equipment, maintaining equipment, customizing equipment, etc.).

U4 – Provide evidence of: Occupational Therapists, Physical Therapists or Speech Pathologists licensed by the Delaware Division of Professional Regulation under Title 24 of the Delaware Administrative Code, sections 2000, 2600 and 3700, respectively, if applicable.

U5 – Provide evidence of being certified by ATP RESNA Rehabilitation Engineering and Assistive Technology Society of North America.

**APPENDIX A**

**HCBS PROVIDER APPLICATION**

**REQUIREMENTS SUMMARY CHECKLIST**

**FOR**

**NON-RECURRING SERVICES**

DDDS uses the same [Requirements Summary Checklist](https://www.dhss.delaware.gov/dhss/ddds/files/RequirementSummaryChecklistNonRecurringServices_Final.docx) (shown on the next page) for both new applicants and for existing providers applying to operate a new service. Agencies may apply for services funded by the Lifespan Waiver (LSW) and/or the Pathways to Employment State Plan Amendment (PTE) authorities.

NEW APPLICANTS must submit all documents listed on the Requirements Summary Checklist.

EXISTING PROVIDERS must submit all documents that are listed on the Requirements Summary Checklist in red font. Existing providers must respond to requirements that are in black font only if there has been a change since its last application OR within the last 2 state fiscal years, whichever is less and must type “NC” indicating “No Change” for all other questions in the Page # column of the Requirements Summary Checklist.



You must use the [Requirements Summary Checklist](https://www.dhss.delaware.gov/dhss/ddds/files/RequirementSummaryChecklist_Final.docx) shown below in your submission. DDDS will reject any submission that does not follow this format.

**You must submit the Requirements Summary Checklist in Word format ONLY**.

**HCBS PROVIDER APPLICATION**

**REQUIREMENTS SUMMARY CHECKLIST**

**NON-RECURRING SERVICES**

| CRITERIA | REQUIREMENT | LABEL | PROVIDER INCLUDED | DDDS | | |
| --- | --- | --- | --- | --- | --- | --- |
| YES | NO | |
| General Requirements | Application to Provide HCBS |  |  |  |  | |
| Requirements Summary Checklist |  |  |  |  | |
| Programs and Services | Agency services and processes | A1 |  |  |  | |
| Professional associations | A3 |  |  |  | |
| Two (2) letters of reference | A7 |  |  |  | |
| Service Integrity | Customer service program | B7 |  |  |  | |
| Customer service example | B8 |  |  |  | |
| Business Practices | Legal structure | C1 |  |  |  | |
| Business documentation | C7 |  |  |  | |
| Service Description | Detailed program narrative of service for each service included in the application. Potential applicants must answer ALL questions for the service(s) for which they are applying. NOTE: These must match services identified on the Application. |  |  |  |  | |
| Assistive Technology (not otherwise covered by Medicaid) | Check Medicaid authority(ies) requested:  Lifespan Waiver  Pathways to Employment |  |  |  |  | |
| Evaluation of participants’ needs | U1 |  |  |  | |
| Payor of last resort | U2 |  |  |  | |
| Maximum benefit for participants | U3 |  |  |  | |
| Licensure – PT, OT, ST | U4 |  |  |  | |
| Certification – RESNA | U5 |  |  |  | |
| Home or Vehicle  Accessibility  Adaptations  (Lifespan Waiver only) | Compliance with building codes, permits OR industry standards and codes | V1 |  |  |  | |
| Experience in providing service | V2 |  |  |  | |
| Qualifications to perform activities | V3 |  |  |  | |
| Licensed contractor (Home Modifications) | V4 |  |  |  | |
| Warranty program | V5 |  |  |  | |
| Specialized Medical Equipment and Supplies (not otherwise covered by Medicaid)  Lifespan Waiver only | Specific categories of supplies and equipment | W1 |  |  |  | |
| Community Transition | Service is one-time support | X1 |  |  |  | |
| Service is used for allowable expenses | X2 |  |  |  | |
| Payor of last resort | X3 |  |  |  | |
|  |  |  |  |  |  | |
| Orientation and Mobility (Pathways to Employment only) | Maximum benefit | Y1 |  |  |  | |
| Tailors service to individual needs | Y2 |  |  |  | |
|  |  |  |  |  | |
|  |  |  |  |  | |
|  |  |  |  |  |  | |
|  |  |  |  |  |  | |
|  | | |  | Y | N | |
| Did the application include all required sections? | | |  |  |  | |
| If “Yes” send packet to Authorized Provider Committee  If “No” send notification to applicant | | |  |  | |  |
| DDDS Signature |  | |  |  | |  |
| Date |  | |  |