**HCBS PROVIDER APPLICATION**

**REQUIREMENTS SUMMARY CHECKLIST**

**DDDS HCBS NON-RECURRINGSERVICES**

**INSTRUCTIONS**

1. You must submit the Requirements Summary Checklist in Word format ONLY.
2. You must submit a response to every question as a separate .pdf document.
3. Do not leave any question blank. DDDS will reject incomplete applications.
4. In the Services sections, complete only those sections that pertain to the service(s) for which you are applying.
5. If you are applying for other services, the label conventions below correspond to the label conventions in the Requirement Summary Checklist for other services.
6. The “Provider Included” column is optional and intended to assist applicants in ensuring they have included all required elements (see Appendix A of the Provider Qualification Instructions document).

| 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 AccessibilityAdaptations(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 | One-time support | X1 | [ ]  |  |  |
| Only 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 Provider Authorization CommitteeIf “No” send notification to applicant |  |  |  |
| DDDS Signature |  |  |  |  |
| Date |  |  |