

PROVIDER Recredentialing APPLICATION

**KATIE BECKETT (Part b), 1915c HOME AND COMMUNITY-BASED SERVICES (HCBS) waivers, EMPLOYMENT and Community First (ECF)CHOICES, and choices services**

*The Department of Disability and Aging (DDA) serves as the recredentialing authority for all 1915c, Employment and Community First (ECF) Waiver program, Katie Beckett (KB) Services- Part A and B (collectively “provider services”), and ECF Providers who provide CHOICES Waiver Services . Effective June 1, 2024, DDA serves as the recredentialing authority for CHOICES Providers who also provide 1915c, and/ or Katie Beckett services.*

*For a guide when completing this application, see the Instructions Page for Provider Recredentialing Application Completion located on the DDA website.*

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| **date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **PROVIDER INFORMATION** | | | | |
| 1. Provider Legal Name: | | | DBA: | |
| 1. Tax ID/FEIN: | 1. NPI: | 1. Medicaid ID: | | 1. Taxonomy: |

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| **AppLICATION Type:** | | | |
| **Recredentialing**  **(Existing Providers Only)** | | | |
| **Please mark the program(s) you are currently contracted to provide:** | | | |
| **1915c Waivers** | **Katie Beckett:**  Part A (*BlueCare*)  Part B (*DDA*) | **ECF CHOICES**  Amerigroup  BlueCare  United Health Care | **CHOICES**  Amerigroup  BlueCare  United Health Care |

# RECREDENTIALING APPLICATION SUBMISSION GENERAL GUIDELINES

To begin the Recredentialing process, please complete this application in its entirety and submit it with all appropriate documentation. If any changes in ownership and /or structure occurs during the Recredentialing process, the applicant is required to notify DDA for further direction via email at [DDAProvider.Application@tn.gov](mailto:DIDDProvider.Application@tn.gov) . Completion and acceptance of this Recredentialing application by DDA is not a guarantee of MCO network participation.

**SUPPORTING DOCUMENTS CHECKLIST**

|  |  |
| --- | --- |
| ***Place a checkmark next to each applicable document you are uploading.***  ***\*Please see attachments 1-3 for requirements.*** | |
| **Applicable Professional Licenses/Certifications** | **Employee Roster** |
| **HCBS self-assessment: Non-Residential** | **Policies (*\*If your agency has not been credentialed or recredentialed by DDA, please submit all required policies and/or submit any policy that has been revised since your last credentialing or recredentialing.*** |
| **HCBS self-assessment: Residential** |  |
| **Certificate of Insurance for the following\*:**  * **Automobile Coverage** (including owned, leased, hired, and non-owned vehicles coverage) with a bodily injury/property damage combined single limits not less than one million, five hundred thousand dollars ($1,500,000.00). * **Comprehensive Commercial General Liability** (including personal injury & property damage, premises/operations, independent Provider, contractual liability and completed operations/products coverage) with bodily injury/property damage combined single limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence and one million, five hundred thousand dollars ($1,500,000.00) aggregate. * **Professional Malpractice Liability** coverage, as may be required by DDA, with a limit of not less than seven hundred fifty thousand dollars ($750,000.00) and one million, five hundred thousand dollars ($1,500,000.00) aggregate. * **Workers' Compensation/ Employers' Liability** (including all States’ coverage) with a limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence for employers’ liability. *\*If an employer has less than 5 employees under TN Law Worker’s Compensation is not required.* | |

# SECTION 1: GENERAL INFORMATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Provider Primary Contact Information** | | | | | |
| 5**.** Address: | | | | | |
| 6. City: | 7. State: | | | 8. Zip Code: | |
| 9. Phone Number: | | | 10. Fax Number: | | |
| 11. Credentialing Contact Name and Title: | | | | | |
| 12. Email Address: | | | 13. Provider Website URL: | | |
| **EXECUTIVE DIRECTORS** | | | | | |
| 14. Katie Beckett Executive Director Name: | |  | | | n/a |
| 15. 1915(c) Executive Director Name: | |  | | | n/a |
| 16. ECF CHOICES Executive Director Name: | |  | | | n/a |
| 17. CHOICES Executive Director Name: | |  | | | n/a |
| **provider primary Mailing Address** | | | | | |
| 18**.** Address: 19.  Same as Primary Address | | | | | |
| 20. City: | 21. State: | | | 22. Zip Code: | |
| 23. Phone Number: | | | 24. Fax Number: | | |
| 25. Contact Name and Title: | | | | | |
| 26. Email Address: | | | 27. Provider Website URL: | | |

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| **ADDITIONAL LOCATION 1** | |  | **ADDITIONAL LOCATION 2** | |  | **ADDITIONAL LOCATION 3** | |
| **Region** | **​​**Choose an item.**​** |  | **Region** | **​​**Choose an item.**​** |  | **Region** | **​​**Choose an item.**​** |
| **Address** |  | **Address** |  | **Address** |  |
| **County** |  | **County** |  | **County** |  |
| **Phone Number** |  | **Phone Number** |  | **Phone Number** |  |
| **Fax Number** |  | **Fax Number** |  | **Fax Number** |  |
| **Managing Director** |  | **Managing Director** |  | **Managing Director** |  |

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| **ADDITIONAL LOCATION 4** | |  | **ADDITIONAL LOCATION 5** | |  | **ADDITIONAL LOCATION 6** | |
| **Region** | **​​**Choose an item.**​** |  | **Region** | **​​**Choose an item.**​** |  | **Region** | **​​**Choose an item.**​** |
| **Address** |  | **Address** |  | **Address** |  |
| **County** |  | **County** |  | **County** |  |
| **Phone Number** |  | **Phone Number** |  | **Phone Number** |  |
| **Fax Number** |  | **Fax Number** |  | **Fax Number** |  |
| **Managing Director** |  | **Managing Director** |  | **Managing Director** |  |

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| **BIlling-Payment/remit address** | | | |
| 28. Address: 29.  Same as Primary Address | | | |
| 30. City: | 31. State: | | 32. Zip Code: |
| 33. Billing Phone Number: | | 34. Billing Fax Number: | |
| 35. Billing Contact Name and Title: | | | |
| 36. Billing Email Address: | | | |
| **Electronic Visit Verification (EVV)**  *\*Applicable for all programs: Personal Assistance, Respite, Supportive Home Care, or Clinical Services (Nursing, Behavior services, Physical Therapy, Occupational Therapy, Nutrition, and Speech Language and Hearing/Pathology)* | | | |
| 37. EVV Contact Name and Title: | | 38. EVV Contact Fax Number: | |
| 39. EVV Contact Phone Number: | | 40.EVV Contact Email Address: | |

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| **Provider Contact Information CONtinued** | | | | | | | | | | | | |
| ***\*Refer to provider’s organizational chart, provider directory, or direct contact with provider*** | | | | | | | | | | | | |
|  | **Contact Name** | | | | **Contact Phone Number** | | | **Contact Email Address** | | | | |
| **Contact for Referral** |  | | | |  | | |  | | | | |
| **Contact for Employment Services** *(If applicable)* |  | | | |  | | |  | | | | |
| **Reportable Event Management Coordinator** *(see REM policy)* |  | | | |  | | |  | | | | |
| **Training Coordinator** |  | | | |  | | |  | | | | |
| **Hours of Operation** | | | | | | | | | | | |
| 24 Hours | | Mon | Tues | Wed | | Thurs | Fri | | Sat | Sun |
| Specific Hours of Operation | |  |  |  | |  |  | |  |  |

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| **Emergency Contact Information (after hours of operation)** | |
| 41. Emergency Contact Name and Title: | 42. Emergency Contact Phone Number: |
| 43. Emergency Contact Email Address: | |

# SECTION 2: PROGRAM SERVICES

**Instruction:** Please select all services and regions the agency is contracted to provide.

**Katie Beckett** **Part A**  **n/a**

**\*CONTRACTED exclusively THROUGH BlueCare**

| **PROGRAM SERVICES** | **West** | **Middle** | **East** |
| --- | --- | --- | --- |
| **PERSONAL ASSISTANCE/ SUPPORTIVE HOME CARE - IN-HOME** | | | |
| Katie Beckett Part A - Supportive Home Care (KB–A SHC) |  |  |  |
| **RESPITE SERVICE** | | | |
| Katie Beckett Part A - Respite (KB–A RES) |  |  |  |
| **ANCILLARY SERVICES** | | | |
| Katie Beckett Part A - Assistive Technology, Adaptive Equipment, and Supplies (KB–A ATAES) |  |  |  |
| Katie Beckett Part A - Minor Home Modification (KB–A MHM) |  |  |  |
| **DAY SERVICES** | | | |
| Katie Beckett Part A - Community Integration Support Services (KB–A CISS) | | | |
| **TRANSPORTATION** | | | |
| Katie Beckett Part A - Community Transportation (KB–A Com Transp) |  |  |  |

**Katie Beckett Part B  n/a**

**\*CONTRACTED exclusively THROUGH DDA**

| **PROGRAM SERVICES** | **West** | **Middle** | **East** |
| --- | --- | --- | --- |
| **PERSONAL ASSISTANCE /SUPPORTIVE HOME CARE-IN HOME** | | | |
| Katie Beckett Part B Supportive Home Care (KB–B SHC) |  |  |  |
| **RESPITE SERVICE** | | | |
| Katie Beckett Part B Respite (KB–B RESP) |  |  |  |
| **ANCILLARY SERVICES** | | | |
| Katie Beckett Part B Assistive Technology, Adaptive Equipment, and Supplies (KB–B ATAES) |  |  |  |
| Katie Beckett Part B Minor Home Modification (KB–B MHM) |  |  |  |
| **DAY SERVICES** |  |  |  |
| Katie Beckett Part B Community Integration Support Services (KB–B CISS) |  |  |  |
| **TRANSPORTATION** |  |  |  |
| Katie Beckett Part B Community Transportation (KB–B COM TRANSP)) |  |  |  |

**1915c WaiverS  n/a**

| **PROGRAM ServiceS** | **West** | **Middle** | **East** |
| --- | --- | --- | --- |
| **RESIDENTIAL SERVICES** | | | |
| DDA 1915c Family Model Residential Support (DDA FMRS) |  |  |  |
| DDA 1915c Medical Residential Services\* (DDA MED RES))  *\*Must apply for Nursing Services* ***and*** *either Residential Habilitation or Supported Living* |  |  |  |
| DDA 1915c Residential Habilitation (DDA RES HAB)) |  |  |  |
| DDA 1915c Semi-Independent Living (DDA SIL) |  |  |  |
| DDA 1915c Supported Living (DDA SL) |  |  |  |
| **Day SERVICES** | | | |
| DDA 1915c Community Participation Supports (DDA CP) |  |  |  |
| DDA 1915c Intermittent Employment & Community Integration Wrap-Around Supports (DDA IECW) |  |  |  |
| DDA 1915c Non-Residential Homebound Support Services (DDA NRHS) |  |  |  |
| DDA 1915c Facility Based Day ( DDA FBD ) |  |  |  |
| **EMPLOYMENT Services** |  |  |  |
| DDA 1915c Supported Employment Discovery (DDA SE IND DSC) |  |  |  |
| DDA 1915 Supported Employment Exploration (DDA SE IND EXP) |  |  |  |
| DDA 1915c Supported Employment Individual - Job Development (DDA SE IND JOB DEV) *[consists of Job Dev (JD) Plan or Self-Employment (SE) Plan, Job Dev (JD)Start-Up or Self- Employment (SE) Start-Up] DDA 1915c - Supported Employment Individual -Job Development* |  |  |  |

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| DDA 1915c Supported Employment Individual - Job Coaching (SE IND JC) *[consists of Job Coaching - Individualized Integrated Employment (JC IIE) and Job Coaching for Self-Employment (JC SE)]* |  |  |  |
| DDA 1915c Supported Employment - Small Group (DDA SE SG) *(Examples include mobile crews, small enclaves and other small groups participating in integrated employment)* |  |  |  |
| DDA 1915c Supported Employment - Benefits Counseling (DDA SE IND BC) |  |  |  |

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| **THERAPY/CLINICAL SERVICES** | | | |
| DDA 1915c Behavior Services (DDA BA SVS) |  |  |  |
| DDA 1915c Nursing (DDA NURS) |  |  |  |
| DDA 1915c Nutrition (DDA NUTR) |  |  |  |
| DDA 1915c Occupational Therapy (DDA OT) |  |  |  |
| DDA 1915c Orientation and Mobility\* (DDA O&M) |  |  |  |
| DDA 1915c Physical Therapy (DDA PT) |  |  |  |
| DDA 1915c Speech, Language and Hearing (DDA SLH) |  |  |  |
| DDA 1915c Speech, Language and Hearing Assistive Technology (DDA SLP) |  |  |  |
| **ANCILLARY SERVICES** | | | |
| DDA 1915c Environmental Accessibility Modifications (DDA EAM) |  |  |  |
| DDA 1915c Personal Emergency Response System (DDA PERS) |  |  |  |
| **ENABLING TECHNOLOGY SERVICES** | | | |
| DDA 1915c Enabling Technology (DDA ETECH) |  |  |  |
| DDA 1915c Specialized Medical Equipment Supplies and Assistive Technology (DDA SMESAT) |  |  |  |
| **PERSONAL ASSISTANCE SERVICE** | | | |
| DDA 1915c Personal Assistance (DDA PA)\* |  |  |  |
| **RESPITE** | | | |
| DDA 1915c Respite (DDA RESP) |  |  |  |
| DDA 1915c Behavioral Respite (DDA BA RESP) |  |  |  |
| **SUPPORT COORDINATION SERVICE** | | | |
| DDA 1915c Support Coordination (DDA SC) *Providers of Support Coordination services are prohibited from providing any other 1915C Waiver service(s). However, Providers of Support Coordination services may apply to provide services under the Katie Beckett A and B, ECF CHOICES, and CHOICES.* |  |  |  |
| **TRANSPORTATION SERVICE** | | | |
| DDA 1915c Individual Transportation (DDA IND TRANSP)  \* *The 1915c Individual Transportation service applies only if requesting the Personal Assistance service, Respite service* ***or*** *Orientation and Mobility service. The 1915c Individual Transportation service is not a* ***stand-alone*** *service.* |  |  |  |

**ECF CHOICES**  **n/a**

| **PROGRAM SERVICES** | **West** | **Middle** | **East** |
| --- | --- | --- | --- |
| **RESIDENTIAL SERVICES** | | | |
| ECF Community Living Supports 1a (ECF CLS 1a) |  |  |  |
| ECF Community Living Supports 1b (ECF CLS 1b) |  |  |  |
| ECF Community Living Supports 2 (ECF CLS 2) |  |  |  |
| ECF Community Living Supports 3 (ECF CLS 3) |  |  |  |
| ECF Community Living Supports 4 (ECF CLS 4) |  |  |  |
| ECF Community Living Supports Family Model 1a (ECF CLS-FM 1a) |  |  |  |
| ECF Community Living Supports Family Model 1b (ECF CLS-FM 1b) |  |  |  |
| ECF Community Living Supports Family Model 2 (ECF CLS-FM 2) |  |  |  |
| ECF Community Living Supports Family Model 3 (ECF CLS FM 3) |  |  |  |
| ECF Community Living Supports Family Model 4 (ECF CLS FM 4) |  |  |  |
| ECF Community Stabilization and Transition (ECF CLS CST) Up to 90 Days\*Days\*  *\*This service is used prior to placing persons in the appropriate level for CLS services. Please select when applying to provide CLS and CLS-FM services.* |  |  |  |
| ECF CLS Behavioral Health Community Stabilization and Transition 2a (ECF CLS BHCST 2a) |  |  |  |
| ECF CLS Behavioral Health Community Stabilization and Transition (ECF CLS BHCST 2b) |  |  |  |
| ECF CLS Emergency Placement (ECF CLS EPCST) *\*This is a temporary service used in conjunction with CLS Services. Please select when applying to provide CLS and CLS-FM services.* |  |  |  |
| ECF Intensive Behavioral Family-Centered Treatment, Stabilization and Supports Group 7 (ECF IBFCTSS 7) |  |  |  |
| ECF Intensive Behavioral Community Transition and Stabilization Services Group 8 (ECF IBCTSS 8) |  |  |  |
| **DAY SERVICE** |  |  |  |
| ECF Community Integrated Support Services (ECF CLS CISS) |  |  |  |
| ECF Independent Living Skills Training (ECF CLS ILST) |  |  |  |
| **EMPLOYMENT SERVICES** |  |  |  |
| ECF Co-Worker Supports (ECF CWS) |  |  |  |
| ECF Discovery (ECF DISC) |  |  |  |
| ECF Exploration for Wage Employment (Also known as Exploration for CIE) (ECF EXPL WE) |  |  |  |
| ECF Job Coaching – Integrated, Competitive Employment (ECF JCICE) |  |  |  |
| ECF Job Coaching - Individual Self-Employment (ECF JCSE) |  |  |  |
| ECF Job Development Plan (ECF JDSEP) |  |  |  |
| ECF Job Development Startup (ECF JDSU) |  |  |  |
| ECF Self-Employment Startup (ECF SESU) |  |  |  |
| ECF Situational Observation and Assessment (ECF SOA) |  |  |  |
| ECF Supported Employment Small Group (Max 2 People) Enclave (ECF SESGE) |  |  |  |
| ECF Supported Employment Small Group (Max 3 People) Mobile Work Crew (ECF SE SGMWC) |  |  |  |
| ECF Integrated Employment Path Services (Time-Limited Prevocational Training) (ECF IEPS) |  |  |  |
| ECF Benefits Counseling *(CWIC, Self Employed or Provider Employed)* (ECF BENE)*(CWIC, Self Employed or Provider Employed)* |  |  |  |
| ECF Career Advancement (ECF CAREER) |  |  |  |
| **ANCILLARY SERVICES** | | | |
| ECF Assistive Technology/Adaptive Equipment and Supplies (ECF ATAES) |  |  |  |
| ECF Minor Home Modifications (ECF MHM) |  |  |  |
| **THERAPY/CLINICAL Services** | | | |
| ECF Specialized Consultation and Training Occupational Therapy (ECF SLT OT) |  |  |  |
| ECF Specialized Consultation and Training Physical Therapy (ECF SLT PT) |  |  |  |
| ECF Specialized Consultation and Training Speech Language Pathology (ECF SLT SLP) |  |  |  |
| ECF Specialized Consultation and Training Nurse Education, Training and Delegation (ECF SLT RN) |  |  |  |
| ECF Specialized Consultation and Training Nutrition (ECF SLT NUTR) |  |  |  |
| ECF Specialized Consultation and Training Behavioral Services (ECF SLT BEHAV SRVS) |  |  |  |
| ECF Specialized Consultation and Training Orientation and Mobility (ECF SLT O&M) |  |  |  |

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| **PERSONAL ASSISTANCE SERVICE** | | | |
| ECF Personal Assistance (ECF PA) |  |  |  |
| ECF Supportive Home Care (ECF SHC) |  |  |  |
| **RESPITE SERVICE** | | | |
| ECF Respite (ECF RESP) |  |  |  |
| **Enabling Technology SERVICES** | | | |
| ECF Enabling Technology (ECF ETECH) |  |  |  |
| **OTHER SERVICES** | | | |
| ECF Community Support, Development, Organization and Navigation (ECF CSDON)Navigation |  |  |  |
| ECF Health Insurance Counseling and Forms Assistance (ECF HICFA) |  |  |  |
| ECF Peer–to-Peer Support Self Direction Employment and Community Support and Navigation (ECF PPSN) |  |  |  |
| ECF Decision Making Supports formerly known as (f.k.a.) Conservatorship and alternative to Conservatorship Counseling (ECF DMS) |  |  |  |
| **TRANSPORTATION SERVICES** | | | |
| ECF Community Transportation *Non-Emergency Transportation/ Stand Alone Transportation* (ECF COM TRANSP) |  |  |  |

**CHOICES**   **n/a**

| **PROGRAM SERVICES** | **West** | **Middle** | **East** |
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| **RESIDENTIAL SERVICES** | | | |
| CHOICES Community Living Supports 1 (CH CLS 1) |  |  |  |
| CHOICES Community Living Supports 2 (CH CLS 2) |  |  |  |
| CHOICES Community Living Supports 3 (CH CLS 3) |  |  |  |
| CHOICES Community Living Supports Family Model 1 (CH CLS FM 1) |  |  |  |
| CHOICES Community Living Supports Family Model 2 (CH CLS FM 2) |  |  |  |
| CHOICES Community Living Supports Family Model 3 (CH CLS FM 3) |  |  |  |
| CHOICES Adult Care Home (HCBS ACH 1) |  |  |  |
| CHOICES Adult Care Home (HCBS ACH 2) |  |  |  |
| CHOICES Assisted Care Living Facility (CH ACF) |  |  |  |
| **DAY SERVICE** | | | |
| CHOICES Adult Day Care (HCBS ADC) |  |  |  |
| **Personal Assistance / SUPPORTIVE HOME CARE – IN-HOME** | | | |
| CHOICES Personal Care (HCBS PCV) |  |  |  |
| **RESPITE SERVICE** | | | |
| CHOICES Respite In-Home (HCBS IHR) |  |  |  |
| **ANCILLARY SERVICES** | | | |
| CHOICES Assistive Technology (HCBS AT) |  |  |  |
| CHOICES Minor Home Modifications (HCBS MHM) |  |  |  |
| CHOICES Personal Emergency Response System - Monthly Fee (HCBS PERS-Mo) |  |  |  |
| CHOICES Personal Emergency Response System- Installation (HCBS PERS-Inst) |  |  |  |

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| **ENABLING TECHNOLOGY** | | | |
| CHOICES Enabling Technology (CHOICES ETECH) |  |  |  |
| **OTHER SERVICES** |  |  |  |
| CHOICES Home-Delivered Meals (CHOICES HDM) |  |  |  |
| CHOICES Pest Control CHOICES PC) |  |  |  |

**SECTION 3: COUNTIES COVERED BY PROGRAM** Select the counties and program(s) the provider serves:

# MIDDLE REGION: All Counties n/a

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **COUNTY** | **KB-A** | **KB-B** | **1915c** | **ECF** | **CHOICES** |  | **COUNTY** | **KB-A** | **KB-B** | **1915c** | **ECF** | **CHOICES** |
| **Bedford** |  |  |  |  |  | **Lewis** |  |  |  |  |  |
| **Cannon** |  |  |  |  |  | **Lincoln** |  |  |  |  |  |
| **Cheatham** |  |  |  |  |  | **Macon** |  |  |  |  |  |
| **Clay** |  |  |  |  |  | **Marshall** |  |  |  |  |  |
| **Coffee** |  |  |  |  |  | **Maury** |  |  |  |  |  |
| **Cumberland** |  |  |  |  |  | **Montgomery** |  |  |  |  |  |
| **Davidson** |  |  |  |  |  | **Moore** |  |  |  |  |  |
| **DeKalb** |  |  |  |  |  | **Overton** |  |  |  |  |  |
| **Dickson** |  |  |  |  |  | **Perry** |  |  |  |  |  |
| **Fentress** |  |  |  |  |  | **Pickett** |  |  |  |  |  |
| **Franklin** |  |  |  |  |  | **Putnam** |  |  |  |  |  |
| **Giles** |  |  |  |  |  | **Robertson** |  |  |  |  |  |
| **Hickman** |  |  |  |  |  | **Rutherford** |  |  |  |  |  |
| **Houston** |  |  |  |  |  | **Smith** |  |  |  |  |  |
| **Humphreys** |  |  |  |  |  | **Stewart** |  |  |  |  |  |
| **Jackson** |  |  |  |  |  | **Sumner** |  |  |  |  |  |
| **Lawrence** |  |  |  |  |  | **Trousdale** |  |  |  |  |  |
| **Lewis** |  |  |  |  |  | **Van Buren** |  |  |  |  |  |
| **Lincoln** |  |  |  |  |  | **Warren** |  |  |  |  |  |
| **Houston** |  |  |  |  |  | **Wayne** |  |  |  |  |  |
| **Humphreys** |  |  |  |  |  | **White** |  |  |  |  |  |
| **Jackson** |  |  |  |  |  | **Williamson** |  |  |  |  |  |
| **Lawrence** |  |  |  |  |  | **Wilson** |  |  |  |  |  |

# WEST REGION: All Counties n/a

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **COUNTY** | **KB-A** | **KB-B** | **1915c** | **ECF** | **CHOICES** |  | **COUNTY** | **KB-A** | **KB-B** | **1915c** | **ECF** | **CHOICES** |
| **Benton** |  |  |  |  |  | **Haywood** |  |  |  |  |  |
| **Carroll** |  |  |  |  |  | **Henderson** |  |  |  |  |  |
| **Chester** |  |  |  |  |  | **Henry** |  |  |  |  |  |
| **Crockett** |  |  |  |  |  | **Lake** |  |  |  |  |  |
| **Decatur** |  |  |  |  |  | **Lauderdale** |  |  |  |  |  |
| **Dyer** |  |  |  |  |  | **Madison** |  |  |  |  |  |
| **Fayette** |  |  |  |  |  | **McNairy** |  |  |  |  |  |
| **Gibson** |  |  |  |  |  | **Obion** |  |  |  |  |  |
| **Hardeman** |  |  |  |  |  | **Shelby** |  |  |  |  |  |
| **Hardin** |  |  |  |  |  | **Tipton** |  |  |  |  |  |
|  |  |  |  |  |  | **Weakley** |  |  |  |  |  |

# EAST REGION: All Counties n/a

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **COUNTY** | **KB-A** | **KB-B** | | **1915c** | **ECF** | **CHOICES** |  | **COUNTY** | **KB-A** | **KB-B** | **1915c** | **ECF** | **CHOICES** |
| **Anderson** |  |  | |  |  |  | **Knox** |  |  |  |  |  |
| **Bledsoe** |  |  | |  |  |  | **Loudon** |  |  |  |  |  |
| **Blount** |  |  | |  |  |  | **Marion** |  |  |  |  |  |
| **Bradley** |  |  | |  |  |  | **McMinn** |  |  |  |  |  |
| **Campbell** |  |  | |  |  |  | **Meigs** |  |  |  |  |  |
| **Carter** |  |  | |  |  |  | **Monroe** |  |  |  |  |  |
| **Claiborne** |  |  | |  |  |  | **Morgan** |  |  |  |  |  |
| **Cocke** |  |  | |  |  |  | **Polk** |  |  |  |  |  |
| **Grainger** |  |  | |  |  |  | **Rhea** |  |  |  |  |  |
| **Greene** |  |  | |  |  |  | **Roane** |  |  |  |  |  |
| **Grundy** |  |  | |  |  |  | **Scott** |  |  |  |  |  |
| **Hamblen** |  |  | |  |  |  | **Sequatchie** |  |  |  |  |  |
| **Hamilton** |  |  | |  |  |  | **Sevier** |  |  |  |  |  |
| **Hancock** |  |  | |  |  |  | **Sullivan** |  |  |  |  |  |
| **Hawkins** |  |  | |  |  |  | **Unicoi** |  |  |  |  |  |
| **Jefferson** |  |  | |  |  |  | **Union** |  |  |  |  |  |
| **Johnson** |  |  | |  |  |  | **Washington** |  |  |  |  |  |
| **Program** | | | **Explain if not all selected services do not apply to all counties selected:** | | | | | | | | | | |
| **1915c Waivers** | | |  | | | | | | | | | | |
| **Katie Beckett** | | |  | | | | | | | | | | |
| **ECF** | | |  | | | | | | | | | | |
| **CHOICES** | | |  | | | | | | | | | | |

# 

# SECTION 4: EMPLOYMENT CERTIFICATION STATEMENT\*

# (\*Applicable to providers applying to be recredentialed for employment services only)

|  |  |  |  |
| --- | --- | --- | --- |
| **Question** | Answer | Signature | Date |
| Do you currently employ a Job Coach? | Choose an item. |  |  |
| Do you currently employ a Job Developer? | Choose an item. |  |  |
| If no, do you plan to hire a credentialed Job Developer or intend to train a staff member to become a Job Developer within the next 12 months? | Choose an item. |  |  |
| Do you currently employ a Job Developer Supervisor? | Choose an item. |  |  |
| If no, do you plan to hire a credentialed Job Developer Supervisor or intend to train a staff member to become a Job Developer Supervisor within the next 12 months? | Choose an item. |  |  |

# SECTION 5: CERTIFICATION STATEMENT

The Certification Statement must contain a signature which is dated by the executive director, chairperson of the board, business owner(s), or other executive manager who is both authorized by the applicant(s) to submit this Provider Recredentialing Application, and to also attest to the truthfulness and accuracy of the information submitted. DDA may terminate any potential provider from participation in the application process due to material misrepresentation or falsification of information.

***I certify the information given in this application is correct and complete to the best of my knowledge. I am aware that should an investigation show any falsification, my agency will not be considered as a potential provider of 1915c Waivers, Katie Beckett-Part A, Katie Beckett-Part B, ECF CHOICES, and/or CHOICES program. I hereby authorize the State of Tennessee to make all necessary investigations concerning the applicant. I further authorize and request each former employer, educational institution, or organization (including law enforcement agencies) to provide all information which may be sought in connection with this application. The agency will carry adequate and appropriate general liability, professional liability, and workers compensation insurance for the protection of persons receiving services, staff, facilities, and the general public.***

**SIGNATURE SECTION**

|  |  |
| --- | --- |
| 1. Agency Name | |
| 2. Name of Authorized Representative: | 3. Title: |
| 4. Signature: | 5. Date: |

# SECTION 5: ATTACHMENTS

* Instructions for Completing Recredentialing Application
* Recredentialing Review Checklist
* Licensure Requirements