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**Managed Care Organization (Mco)**

**contract and county expansion request form**

*The Department of Disability and Aging (DDA) serves as the credentialing 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 credentialing authority for CHOICES Providers who also provide 1915c, and/ or Katie Beckett services.*

**INTRODUCTION***: The purpose of this form is to* ***request a contract with an additional MCO for the services and counties the agency is currently credentialed or recredentialed to provide AND/OR to add counties per your contracted region(s).***

*This form is to be completed by currently contracted providers in the following programs: Katie Beckett- Part A, Katie Beckett- Part B, 1915c Home and Community Based Services (HCBS) waivers, Employment Community First (ECF) CHOICES, and CHOICES Waiver Services.*

##### INSTRUCTION:

##### For MCO addition, please complete THE entire application.

##### For county addition, please complete the “provider information”, “Currently Contracted Programs and Services”, AND “Counties of service” sections only.

## ***\*\*\* Please complete the Expansion CREDENTIALING Application if you wish to ADD programs, services, and/or regions \*\*\****

# **DATE OF REQUEST: Click or tap to enter a date.**

|  |  |
| --- | --- |
| **APPLICATION TYPE:** | [ ]  **ADD MCO**[ ]  **ADD COUNTY** |

# Provider Information

|  |  |
| --- | --- |
|  **Provider Legal Name:** | **DBA:** |
|  Tax ID/FEIN: | NPI: | Medicaid ID: | Taxonomy: |
| **Provider Primary Contact Information** |
|  Address: |
|  City: |  State: |  Zip Code: |
|  Phone Number: |  Fax Number: |
|  Credentialing Contact Name and Title: |
|  Email Address: |  Provider Website URL: |

**Employment Community First (ECF) CHOICES AND**

**ECF Providers who provide CHOICES Waiver Services**

**Request to add managed care organization**

Please complete entire application indicating the services and counties you are currently contracted to provide and would like to provide with the MCO requested below.

# **mark requested Managed Care Organization (MCO):**

[ ]  Wellpoint [ ]  BlueCare [ ]  United Health Care

# **Date of most recent credentialing or recredentialing date: Click or tap to enter a date.**

# APPLICATION SUBMISSION

1. See the Submission Links below, submit the application to the region you are requesting to provide the service.
2. If requesting to provide services in multiple regions, submit the application to the region in which your main office is located.
3. **Note**: When naming your application include the name of your organization as part of the title in each uploaded document each time you submit information. Example:  ABC application, ABC background checks, ABC Disclosure form, etc. If the uploaded application and supporting documents are not preceded by the initials from your company’s name this may delay the downloading process and credentialing of your application submission.
4. **Note:** If you decide to upload a ZIP FILE. Please ensure the file states the name of your organization.
5. DDA will email confirmation of your application within two (2) business days. It is very important you contact DDA if you do not receive this email.
6. Please allow 30 calendar days before requesting the status of your application.
7. For questions, contact the DDA Provider Enrollment Coordinator by email at DIDDProvider.Application@tn.gov or by phone at (615) 532-6530

**Submission Links:**

East TN Region OwnCloud Link: <https://tncloud.tn.gov/owncloud/index.php/s/xlvnxMJ64D4z0Gz>

Password: upload

Middle TN Region OwnCloud Link: <https://tncloud.tn.gov/owncloud/index.php/s/mHNGfeP0oq6B9Uu>

Password: upload

West TN Region OwnCloud Link: <https://tncloud.tn.gov/owncloud/index.php/s/PGWdmqFkXRY0XFN>

Password: upload

|  |
| --- |
| **EXECUTIVE DIRECTORS** |
| **Program** | **Executive Director Name** | **Mark if n/a** |
| **Katie Beckett**  |  | [ ]  N/A |
| **1915c HCBS Waiver**  |  | [ ]  N/A |
| **ECF CHOICES**  |  | [ ]  N/A |
| **CHOICES**  |  | [ ]  N/A |

# \***Principals Information**

|  |
| --- |
| **OWNER(S)** |
| **NAME** | **SOCIAL SECURITY NUMBER** | **DATE OF BIRTH** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **EXECUTIVE DIRECTOR/MANAGING EMPLOYEE**  |
| **NAME** | **SOCIAL SECURITY NUMBER** | **DATE OF BIRTH** |
|  |  |  |
|  |  |  |
| **BOARD CHAIRPERSON (NOT FOR PROFIT) \*CANNOT BE SAME AS ED** |
| **NAME** | **SOCIAL SECURITY NUMBER** | **DATE OF BIRTH** |
|  |  |  |

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| --- |
| **BIlling-Payment/remit address** |
| Address: [ ]  Same as Primary Address |
|  |
| City: |  | State: |  | Zip Code: |  |
| Billing Phone Number: |  | Billing Fax Number: |  |
| **Billing Contact Name and Title:** |  |
| **Billing Email Address:** |  |

|  |
| --- |
| **Electronic Visit Verification (EVV), *if applicable*:** |
| EVV Contact Name and Title: |  | EVV Contact Fax Number:  |  |
| EVV Contact Phone Number: |  | EVV Contact Email Address:  |  |

|  |
| --- |
| **Hours of Operation** |
| [ ]  24 Hours | [ ]  Mon | [ ]  Tues | [ ]  Wed | [ ]  Thurs | [ ]  Fri | [ ]  Sat | [ ]  Sun |
| [ ]  Specific Hours of Operation |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Emergency Contact Information (after hours of operation)** |  |
| **Emergency Contact Name and Title:** | **Emergency Contact Phone Number:** | **Emergency Contact Email Address:** |
|  |  |  |

**CURRENTLY CONTRACTED Programs and Services:**

Please mark the services and programs you are currently contracted to provide.

# **Katie Beckett – Part A**

**PERSONAL ASSISTANCE/SUPPORTIVE HOME CARE**

**IN HOME SERVICE**

[ ]  Supportive Home Care (KB–A SHC)

**RESPITE SERVICE**

[ ]  Respite (KB–A RES)

**ANCILLARY SERVICES**

[ ]  Assistive Technology, Adaptive Equipment, and Supplies–A KB-KB-A ATAES)

☐ Minor Home Modification (KB–A MHM)

**DAY SERVICE**

 ☐ - Community Integration Support Services (KB–A CISS)

**TRANSPORTATION** **SERVICE**

[ ]  Community Transportation (KB–A CTRANS)

**Katie Beckett – Part B**

**PERSONAL ASSISTANCE/SUPPORTIVE HOME CARE**

**IN HOME SERVICE**

[ ]  Supportive Home Care (KB–B SHC)

**RESPITE SERVICE**

[ ]  Respite (KB–B RES)

**ANCILLARY SERVICES**

[ ]  Assistive Technology, Adaptive Equipment, and Supplies–A KB\_B KB-B ATAES)

☐ Minor Home Modification (KB–B MHM)

**DAY SERVICE**

 ☐ - Community Integration Support Services (KB–B CISS)

**TRANSPORTATION** **SERVICE**

[ ]  Community Transportation (KB–B CTRANS)

# **1915C WAIVERS**

**RESIDENTIAL SERVICES**

[ ]  DDA 1915c Family Model Residential Support (DDA FMRS)

[ ]  DDA 1915c Medical Residential Services\* (DDA MED RES)

[ ]  DDA 1915c Residential Habilitation (DDA RES HAB)

[ ]  DDA 1915c Semi-Independent Living (DDA SIL)

[ ]  DDA 1915c Supported Living (DDA SL)

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**DAY SERVICES**

[ ]  DDA 1915c Community Participation Supports (CP)

[ ]  DDA 1915c Intermittent Employment & Community Integration Wrap-Around Supports (IECW)

[ ]  DDA 1915c Non-Residential Homebound Support Services (NRSHMB

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**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 SE - Ind JD*

[ ]  1915cSupported 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)*

[x]  DDA 1915c Supported Employment - Benefits Counseling (DDA SE IND BC)

**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) |

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| **ANCILLARY SERVICES**[ ]  DDA 1915c Environmental Accessibility Modifications (DDA EAM) | **ENABLING TECHNOLOGY SERVICES**[ ]  DDA 1915c Enabling Technology (DDA ETECH) |
| [ ]  DDA 1915c Personal Emergency Response System (DDA PERS)

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 | [ ]  DDA 1915c Specialized Medical Equipment Supplies and Assistive Technology (DDA SMESAT) |
| **PERSONAL ASSISTANCE SERVICE** [ ]  DDA 1915c Personal Assistance (DDA PA)\* |  |
| **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**

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**DAY SERVICES**

[ ]  ECF Independent Living Skills Training (ECF CLS ILST)

[ ]  ECF Community Integrated Support Services (ECF CLS CISS)

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**RESIDENTIAL SERVICES**

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| [ ]  *ECF Community Stabilization and Transition (ECF CLS CST) Up to 90 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 Community Living Supports (ECF CLS ) Level: [ ]  1a [ ]  1b [ ]  2 [ ]  3 [ ]  4[ ]  ECF Community Living Supports Family Model (ECF CLS) Level: [ ]  1a [ ]  1b [ ]  2 [ ]  3 [ ]  4[ ]  ECF Behavioral Health Community Stabilization and Transition (ECF CLS BHCST) Level: [ ]  2a [ ]  2b [ ]  ECF 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) |

**EMPLOYMENT Services**

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| --- |
| [ ]  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 - 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: Prevocational Training (ECF IEPS) |
| [ ]  ECF Benefits Counseling (ECF BENE)  |
| [ ]  ECF Career Advancement (ECF CAREER) |

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| --- | --- |
| **ANCILLARY SERVICES**[ ]  ECF Assistive Technology/Adaptive Equipment and Supplies (ECF ATAES) | **PERSONAL ASSISTANCE SERVICE** [ ]  ECF Personal Assistance (ECF PA)) |
|

|  |
| --- |
| [ ]  ECF Minor Home Modifications (ECF MHM) |
|  |

 | [ ]  ECF Supportive Home Care (ECF SHC) |
| **RESPITE SERVICE** [ ] ECF Respite (ECF RESP) | **Enabling Technology SERVICE**[ ]  ECF Enabling Technology (ECF ETECH) |
| **TRANSPORTATION SERVICE** [ ]  ECF Community Transportation *Non-Emergency Transportation/ Stand Alone Transportation* (ECF COM TRANSP) | *.* |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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) |

**Other Services**

|  |
| --- |
| [ ]  ECF Community Support, Development, Organization and Navigation (ECF CSDON) Navigation |
| [ ]  ECF Health Insurance Counseling / 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) |

# **CHOICES**

**Residential Services**

CHOICES Community Living Supports (HCBS CLS):
Level [ ]  1 [ ]  2 [ ]  3

CHOICES Community Living Supports – Family Model (HCBS-FM): Level [ ]  1 [ ]  2 [ ]  3

CHOICES Adult Care Home

((HCBS ACH): Level [ ]  1 [ ]  2

[ ]  CHOICES Assisted Care Living Facility(HCBS ACF)

**DAY SERVICES:**

[ ]  CHOICES Adult Day Care(HCBS ADC)

**PERSONAL ASSISTANCE / SUPPORTIVE HOME CARE – IN-HOME**

[ ]  CHOICES Personal Care (HCBS PC)

**RESPITE:**

[ ]  CHOICES Respite – In-Home(HCBS IHR)

**ENABLING TECHNOLOGY:**

[ ]  CHOICES Enabling Technology(CHOICES ETECH)

**OTHER SERVICES:**

[ ]  CHOICES Home Delivered Meals(CHOICES HDM)

[ ]  CHOICES Pest Control(CHOICES PC)

**ANCILLARY SERVICES:**

[ ]  CHOICES Minor Home Modifications(HCBS MHM)

[ ]  CHOICES Personal Emergency Response System- Installation (HCBS PERS-Inst)

[ ]  CHOICES Personal Emergency Response System-Monthly Fee (HCBS PERS-Mo)

☐ CHOICES Assistive Technology(HCBS AT)

**EMPLOYMENT SERVICES**

|  |
| --- |
| [ ]  CHOICES Exploration for Wage Employment (CHOICES EXPL) |
| [ ]  CHOICES Exploration for Self-Employment (CHOICES EXPL-SE) |
| [ ]  CHOICES Discovery (CHOICES DISC ) |
| [ ]  CHOICES Situational Observation and Assessment (CHOICES SOA) |
| [ ]  CHOICES Job Dev Plan (CHOICES  JDP) |
| [ ]  CHOICES Self-Employment Plan (CHOICES  SEP) |
| [ ]  CHOICES Job Dev Start Up (CHOICES JDSU) |
| [ ]  CHOICES Self-Employment Start Up(CHOICES SESU) |
| [ ]  CHOICES Job Coaching – Integrated, Competitive Employment (CHOICES JCICE) |
| [ ]  CHOICES Job Coaching - Self-Employment (CHOICES JCSE) |
| [ ]  CHOICES Co-Worker Supports (CHOICES CWS ) |
| [ ]  CHOICES Integrated Employment Path Services: Pre-Vocational (CHOICES IEPS:PV) |
| [ ]  CHOICES Career Advancement (CHOICES CAREER) |
| [ ]  CHOICES Benefits Counseling (CHOICES BENE)  |

**PLease indicate counties of service**

# **COUNTIES COVERED BY PROGRAM**

**MIDDLE REGION:**

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

**EAST REGION:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **COUNTY** | **CONTRACTED** | **ADD** |  | **COUNTY** | **CONTRACTED** | **ADD** |  | **COUNTY** | **CONTRACTED** | **ADD** |
| Anderson |  |  | Hamblen |  |  | Monroe |  |  |
| Bledsoe |  |  | Hamilton |  |  | Morgan |  |  |
| Blount |  |  | Hancock |  |  | Polk |  |  |
| Bradley |  |  | Hawkins |  |  | Rhea |  |  |
| Campbell |  |  | Jefferson |  |  | Roane |  |  |
| Carter |  |  | Johnson |  |  | Scott |  |  |
| Claiborne |  |  | Knox |  |  | Sequatchie |  |  |
| Cocke |  |  | Loudon |  |  | Sevier |  |  |
| Grainger |  |  | Marion |  |  | Sullivan |  |  |
| Greene |  |  | McMinn |  |  | Unicoi |  |  |
| Grundy |  |  | Meigs |  |  | Union |  |  |
|  |  | Washington |  |  |

**WEST REGION:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **COUNTY** | **CONTRACTED** | **ADD** |  | **COUNTY** | **CONTRACTED** | **ADD** |  | **COUNTY** | **CONTRACTED** | **ADD** |
| Benton |  |  | Gibson |  |  | Lauderdale |  |  |
| Carroll |  |  | Hardeman |  |  | Madison |  |  |
| Chester |  |  | Hardin |  |  | McNairy |  |  |
| Crockett |  |  | Haywood |  |  | Obion |  |  |
| Decatur |  |  | Henderson |  |  | Shelby |  |  |
| Dyer |  |  | Henry |  |  | Tipton |  |  |
| Fayette |  |  | Lake |  |  | Weakley |  |  |

# **Explain if not all CONTRACTED services apply to all counties selected:**

|  |  |  |
| --- | --- | --- |
| **Program** | **lIST THE service** | **list THE COUNTY** |
| **Katie Beckett – Part A** |  |  |
| **Katie Beckett – Part B** |  |  |
| **1915c Waivers** |  |  |
| **Employment and Community First (ECF) CHOICES** |  |  |
| **CHOICES** |  |  |

**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 agency to submit this request, and to also attest to the truthfulness and accuracy of the information submitted.*

*Completion and submission of this form is not a guarantee of MCO network participation.*

**SIGNATURE SECTION**

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

**All questions and correspondence should be directed to the Provider Enrollment Coordinator by email at** **DIDDProvider.Application@tn.gov** **or by phone at (615) 532-6530.**