

New PROVIDER Credentialing APPLICATION

**for the following programs:**

KATIE BECKETT (Part A), KATIE BECKETT (Part B), 1915c HOME AND COMMUNITY-BASED SERVICES (HCBS) waivers, employment and community first (ECF) choices, and Choices\*

**INTRODUCTION**: This application is to be completed by an entity (e.g., individual, group, agency, or other type of organization) seeking to provide the following programs: Katie Beckett- Part A, Katie Beckett -Part B, 1915c Home and Community-Based Services (HCBS) Waivers, Employment and Community First (ECF) CHOICES, and CHOICES (for details see the Program Scope below)\*. These programs are administered by the Department of Intellectual and Developmental Disabilities (DIDD) and the Managed Care Organizations (MCOs): Wellpoint, BlueCare, and United Health Care.

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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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| 6 .AppLICATION Type: |
| [ ]  **New Provider**[ ]  **Contracted Clinical & Ancillary**  |
| 7.Program(s) Applying For: |
| [ ]  **DIDD 1915c Waivers** | [ ]  **Katie Beckett:** **☐MCO Part A (*BlueCare*)**[ ]  **DIDD Part B**  | [ ]  **MCO ECF CHOICES** | [ ]  **MCO CHOICES** |

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| \*PROGRAM SCOPE |

\*1. If you only want to provide CHOICES services, credentialing is conducted by the MCO (Wellpoint, BlueCare, United Health Care then contact the MCO for their application and submit it directly to the MCO. Otherwise,

if you are a new provider applicant requesting to provide CHOICES along with any of the following programs 1915c, ECF CHOICES, or Katie Beckett, complete and submit the **New Provider Credentialing Application** to the DIDD.

\*2. if you are a new provider applicant requesting to provide any of the other programs 1915c, ECF, or Katie Beckett complete and submit the **New Provider Credentialing Application** to DIDD.

\*3. If you are a currently contracted provider for any of the following programs: Katie Beckett, 1915c, ECF CHOICES, or CHOICES, requesting to add to your contract complete the appropriate Expansion Applications**: MCO Contract and County Expansion Request Form and/or Expansion Credentialing Application** and submit to the DIDD. \*4. If you are a contracted Clinical & Ancillary provider requesting additional Clinical & Ancillary services, complete the **Expansion Credentialing Application** and submit to the DIDD. .

# CREDENTIALING APPLICATION SUBMISSION GENERAL GUIDELINES

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. DIDD will email confirmation of your application within two (2) business days. It is very important you contact DIDD 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 DIDD 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

To begin the contracting and credentialing process, please complete this application in its entirety and submit it with all appropriate documentation. Applications that do not include all requested information will not be processed. A separate application, disclosure form, tax forms, and supporting documents are required for each program operating under separate National Provider Indicator (NPI) numbers or separate tax identiﬁcation numbers. If any changes in ownership and /or structure occurs during the credentialing process, the applicant is required to notify DIDD for further direction via email at DIDDProvider.Application@tn.gov.

Please select the type of application, program(s), service(s), and region(s) you are applying to participate in. Prior to selecting the service, review the service definition and license requirements. For services with multiple levels, you must select **each** level you wish to provide. EXAMPLE: If you would like to only provide CLS-level 4 then you will not select the other levels. Ensure all information is complete and aligns with your Tennessee Secretary of State registration.

The applicant must provide a signature and date where indicated, an electronic signature is acceptable, but a handwritten signature is required for the VECHS-Waiver Form. Only one set of supporting documents should be submitted regardless of the number of programs/services requiring the same document. Graphic files such as:  JPEG (photo) or TIFF, will not be accepted. Reference the “How to Become a Credentialed Provider” [How to Become a Credentialed Provider (tn.gov)](https://www.tn.gov/didd/providers/provider-credentialing-application.html) site for application, instructions, tools, and forms to be submitted with your application.  This includes, but is not limited to, specific supporting documents required for each application/service type.

Completion and acceptance of this credentialing application by DIDD is not a guarantee of MCO network participation. DIDD/MCO policies and procedures will govern appeals related to network participation.

Providers must have a valid Tennessee Medicaid ID number for credentialing purposes and to contract with DIDD/TennCare Managed Care Organization(s). If you have not registered with TennCare, we cannot accept your application. To register with TennCare, please visit: <http://tn.gov/tenncare>/Providers/Provider Registration

# **Prerequisites**

The following must be completed prior to submission of the credentialing application. *Items 1-5 must be completed before you may proceed to the TennCare Registration Portal and obtain your Medicaid ID****.***

1. **Service/Professional licenses:** **FOR SPECIFIC DETAILS SEE each service definition AND ATTACHMENT 2 Licensing Requirement**
	1. **PROFESSIONAL License(s)/CERTIFICATIONS:** *For example, when applying to provide Behavioral services, Nursing, Occupational Therapy, the applicant must submit the individual’s professional license.*
	2. **SERVICE License(s):** Applicable service licenses pertain to residential, day, personal assistance, and other services. *For example: in the Residential category, the applicant must submit the required residential license from DIDD’s licensure Division*.
	3. **PROFESSIONAL SERVICES SUPPORT LICENSE (PSSL)**: *This is applicable to 1915c clinical/therapy services and is issued by the Tennessee Department of Health. \*Please note: this license is not issued until after the completion of the credentialing process and therefore a copy is not required during credentialing. However, this must be obtained and uploaded before your contract may be executed.*
2. **FEDERAL TAX ID:** This is issued by the Federal Government’s Internal Revenue Service. *Please visit their website for instructions and questions.*
3. **Registration with the Tennessee Secretary of State (if applicable):** P*lease visit the Tennessee Secretary of State website to register your business. The business must remain in an "Active”* status.
4. **TAXONOMY:** The provider type and specialty for the services your agency offers sets the taxonomy.  Please refer to the national taxonomy list set by CMS for information and questions.
*For Example: If you register as a “HCBS-In Home Supportive Care (Pest Control, etc.)” provider there are certain requirements to enroll as that provider type and taxonomy which will need to be met in the TennCare Provider Portal.*

**5. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER:** The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions. *Please visit the National Plan & Provider Enumeration System (NPPES) website for registration, instructions, and frequently asked questions.*

**6. TENNCARE PROVIDER REGISTRATION PORTAL:** This system is used by TennCare for each provider of services. This includes but is not limited to business and vendor information, ownership information, practice locations, sub-contracts, services authorized, licenses, and additional information.

* 1. **If you have not registered with TennCare, we cannot accept your application.**
	2. To register with TennCare, please visit: [PDMS User Login - 3497154c-d926-42fd-b5eb-86c6a541fd23 (tn.gov)](https://pdms.tenncare.tn.gov/Account/Login.aspx?ReturnUrl=%2fProcess%2fRegistration.aspx)
	3. **For questions and information, please visit**: <https://www.tn.gov/tenncare/providers/provider-registration.html>
	4. **Please note:** the system only allows **sixty (60) days** to complete the registration. This includes uploading copies of licenses and tax forms. Failure to meet this deadline will require you to start the registration process over.

**7. MEDICAID ID NUMBER:**

**What is a Medicaid ID and when can I use it?** Before a provider can be considered for participation in TennCare, registration with the Division of TennCare is required. TennCare issues a Medicaid ID to eligible providers who have completed the registration process. Without a valid, active Medicaid ID, providers cannot be considered for contracting with any TennCare Managed Care Organization or receive payment for services rendered to TennCare enrollees.

1. Applicants/providers are required to obtain a valid Medicaid ID number for credentialing purposes and to contract with DIDD/TennCare Managed Care Organization(s). *This is issued by the Tennessee Division of TennCare through the TennCare Provider Registration Portal.*
2. To obtain the Medicaid ID number, the service license(s) for each service being requested must be obtained and uploaded into the applicant’s TennCare Provider Portal account.
3. See *Attachment 2 Licensure Requirement* and contact the appropriate licensure (DIDD, Department of Health, etc.) to obtain the appropriate service license.

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| **Provider Primary Contact Information** |
| 8.Address: |
| 9. City: | 10. State: | 11. Zip Code: |
| 12. Phone Number: | 13. Fax Number: |
| 14. Credentialing Contact Name and Title: |
| 15. Email Address: | 16. Provider Website URL: |
| **EXECUTIVE DIRECTORS** |
| 17. Katie Beckett Executive Director Name: |  | [ ]  n/a |
| 18. 1915(c) Executive Director Name: |  | [ ]  n/a |
| 19. ECF CHOICES Executive Director Name: |  | [ ]  n/a |
| 20. CHOICES Executive Director Name: |  | [ ]  n/a |

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| **PLEASE INDICATE THE NAMES, SOCIAL SECURITY NUMBERS, AND DATES OF BIRTH FOR THE POSITIONS NOTED BELOW. SHOULD A PERSON PERFORM MORE THAN ONE DUTY THEN ONLY ONE SET OF NUMBERS IS NEEDED. THIS INFORMATION WILL BE USED BY DIDD TO PERFORM STATE REGISTRY CHECKS.**  |

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| **21.**  **OWNER(S)** |
| **Name** | **Social Security Number** | **Date of Birth** |
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| **22. EXECUTIVE DIRECTOR/MANAGING EMPLOYEE** |
| **Name** | **Social Security Number** | **Date of Birth** |
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| **23. BOARD CHAIRPERSON (NOT FOR PROFIT ENTITY)** |
| **Name** | **Social Security Number** | **Date of Birth** |
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| **provider Mailing Address** |
| 24**.** Address: 25. [ ]  Same as Primary Address |
| 26. City:  | 27. State: | 28. Zip Code: |
| 29. Phone Number: | 30. Fax Number: |
| 31. Contact Name and Title: |
| 32. Email Address: | 33. Provider Website URL: |
| **BIlling-Payment/remit address** |
| 34. Address: 35. [ ]  Same as Primary Address |
| 36. City: | 37. State: | 38. Zip Code: |
| 39. Billing Phone Number: | 40. Billing Fax Number: |
| 41. Billing Contact Name and Title: |
| 42. Billing Email Address: |
| **Electronic Visit Verification (EVV*)*** *Complete the EVV section and* provide an EVV policy, if you are requesting to provide the following services: *Personal Assistance, Respite, Supportive Home Care, Nursing, Behavior services, Physical Therapy, Occupational Therapy, Speech Language and Hearing, and Nutrition.* |
| 43. EVV Contact Name and Title: | 44. EVV Contact Fax Number: |
| 45. EVV Contact Phone Number: | 46. EVV Contact Email Address: |

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| **47. 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)** |
| 48. Emergency Contact Name and Title: | 49. Emergency Contact Phone Number: |
| 50. Emergency Contact Email Address: |

# SECTION 2: ADDITIONAL INFORMATION & QUESTIONS

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| **Medicaid Certified** | **Minority Business** | **Minority Bus, Certified** | **Veteran Owned Business** |
| [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** |
| 1. Population(s) Served:
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| 1. Did the provider complete Cultural competency training?
 | [ ]  Yes | [ ]  No |
| 1. Is the provider an Indian Healthcare provider?
 | [ ]  Yes | [ ]  No |
| 1. Does this office meet (Americans with Disabilities Act) accessibility requirement?
 | [ ]  Yes | [ ]  No |
| 1. Does the provider have interpretation services? *If yes, please indicate what type*:
 | [ ]  Yes | [ ]  No |
| 1. Does the provider have any other cultural or linguistic services (including ASL)?

*If yes, please indicate what type:*  | [ ]  Yes | [ ]  No |
| 1. Languages provided:
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# SECTION 3: OPTIONAL DEMOGRAPHICS INFORMATION

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| **Business Ownership** *(please select all which apply)* |  | **Ownership Ethnicity** *(please select one)* |
| [ ]  | G | Government Owned | [ ]  | A | Asian |
| [ ]  | E | Race/Ethnic | [ ]  | B | African American |
| [ ]  | N | Non-Minority Owned | [ ]  | H | Hispanic |
| [ ]  | W | Female Owned | [ ]  | I | Native American Indian |
| [ ]  | P | Non-Profit Background (Minority Owned) | [ ]  | C | Caucasian |
| [ ]  | O | Other |

# SECTION 4: GENERAL QUESTIONS

*For each question with a yes response, the applicant is required to submit details and final disposition as noted.*

| **QUESTION** | **Answer** |
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| 1. Has the provider had any professional liability claim judgments or settlements?
 | Choose an item. |
| 1. Has the business ever had its professional liability coverage canceled or not renewed?
 | Choose an item. |
| 1. Has the business been denied participation, suspended from, or denied renewal from Medicare or Medicaid?
 | Choose an item. |
| 1. Has the business been denied accreditation by its selected accrediting body or had its accreditation status reduced, suspended, revoked or in any way revised by the accrediting body?
 | Choose an item. |
| 1. Has any business owner, board member, or the executive director had a license denied, revoked, suspended, placed on probation, or surrendered to avoid loss of license or disciplinary action in Tennessee or another State?

***\*If yes, attach a statement with the application which specifies the state, business name, details, and legal disposition of such action.*** | Choose an item. |
| 1. Has the license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced, or not renewed?
 | Choose an item. |
| 1. Does any business owner, board member, or the executive director have a license in Tennessee or in another state who is currently under investigation/litigation by a licensing body or is personally under investigation/litigation by a licensing body? ***\*If yes, attach a statement with the application specifying the type of license (if applicable), applicable state and a detailed explanation regarding the investigation/litigation, why it originated and current status.***
 | Choose an item. |
| 1. Has any business owner, board member, or the executive director been the business owner, board member, or executive director of an entity who has had a contract to provide Medicaid or Medicare Services barred, suspended, or terminated in any State within the past five (5) years?  ***\*If yes, attach a statement specifying the state, business name, and provide details regarding the termination.***
 | Choose an item. |
| 1. Has the business owner, any board member or board chairperson, and/or executive director been found to be directly responsible for Medicaid fraud or fraudulent activities against a state or federal agency? **\**If yes, attach detailed documentation including the year of occurrence, state in which it occurred and related legal documentation.***
 | Choose an item. |
| 1. Has your agency provided (or is currently providing) any Medicaid funded services within Tennessee or another state? ***\*If yes, please supply the following with your application: For a new agency, a statement/resume attached supplying sufficient information on who provided the service, the business name, the types of service(s) and evidence of the length and location of such service(s); OR for an existing or previously approved agency, satisfaction survey results regarding the last two (2) years and/or the results of the most recent Quality Assurance Review which demonstrates good standing.***
 | Choose an item. |
| 1. Does any business owner, board member, or the executive director have a history of poor performance on behalf of the applicant due to evidence of repeated poor performance within the past five (5) years, either as a current DIDD/MCO provider or as another provider in Tennessee or any other state? ***\*If yes, attach a statement specifying the state, business name, dates, and provide details regarding the agency’s performance.***
 | Choose an item. |
| 1. Has the business owner, board member, board chairperson, and/or the executive director been determined to be directly responsible for a provider’s closure or termination of a DIDD provider agreement or MCO contract due to negligence in performance of duties in a similar position of administrative responsibility? **\**If yes, attach detailed documentation explaining such closure or termination***
 | Choose an item. |
| 1. Has any business owner, board member, or the executive director ever filed personal or business bankruptcy? ***\*If yes, attach with the applicable a detailed explanation of the bankruptcy which includes legal documentation showing the bankruptcy was dismissed.***
 | Choose an item. |
| 1. Has any business owner, board member, or executive director ever defaulted on monies owed to DIDD and/or the MCOs? ***\*If yes, attach detailed documentation explaining how the debt was resolved.***
 | Choose an item. |

SECTION 5: PROGRAM SERVICES

**Scope of Services**: Applicants may apply to become a credentialed provider of Katie Beckett (KB) ,1915c Waivers, Employment and Community First CHOICES (ECF), and CHOICES . Please see the Attachments 1-4 for additional information and requirements at

[How to Become a Credentialed Provider (tn.gov)](https://www.tn.gov/didd/providers/provider-credentialing-application.html)

**InstructionS:** Prior to selecting the program service(s) and region(s) you are applying to participate in, review the attachments 1-4: Credentialing Standards, License Requirements, Policy Requirements, and Service Definitions. Please select each service you wish to provide under the corresponding program ( Katie Beckett: Part A or B, 1915c Waivers, ECF Choices, and/or CHOICES). You will also mark the region(s) you wish to serve.

**NOTES**: When selecting the areas, including region(s) and or county(ies) the applicant shall note the following:

* Credentialed 1915c and Katie Part-B providers will be qualified for all counties in the selected Region(s).
* ECF Choices, CHOICES, Katie Part-A providers will be credentialed only under the counties and services selected.  However, the MCOs contract is based on network capacity, county and services needed.

### **Please select all services and region(s) the provider will offer for the following:**

[ ]  **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 Resp) |[ ] [ ] [ ]
| **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 SERVICE** |
| Katie Beckett Part A - Community Integration Support Services (KB–A CISS) |[ ] [ ] [ ]
| **TRANSPORTATION** **SERVICE** |
|  Community Transportation (KB–A Com Transp) |[ ] [ ] [ ]

[ ]  **Katie Beckett Part B** [ ]  **n/a**

**\*CONTRACTED exclusively THROUGH DIDD**

| **PROGRAM SERVICES** | **West** | **Middle** | **East** |
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| **PERSONAL ASSISTANCE /SUPPORTIVE HOME CARE-IN HOME SERVICE** |
| 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 SERVICE** |
| Katie Beckett Part B Community Integration Support Services (KB–B CISS) |[ ] [ ] [ ]
| **TRANSPORTATION SERVICE** |
| Katie Beckett Part B Community Transportation (KB–B COM TRANSP) |[ ] [ ] [ ]

[ ]  **1915c WaiverS** [ ]  **n/a**

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

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| DIDD 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)]*  |[ ] [ ] [ ]
| DIDD 1915c Supported Employment - Small Group (DIDD SE SG)*(Examples include mobile crews, small enclaves and other small groups participating in integrated employment)*  |[ ] [ ] [ ]
| DIDD 1915c Supported Employment - Benefits Counseling (DIDD SE IND BC) |[ ] [ ] [ ]

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| **THERAPY/CLINICAL Services** |
| DIDD 1915c Behavior Services: Behavior Analyst (DIDD BA) |[ ] [ ] [ ]
| DIDD 1915c Behavior Services: Behavior Specialist (DIDD BS)*\*Must have a Behavior Analyst to provide oversight.*  |[ ] [ ] [ ]
| DIDD 1915c Nursing (DIDD NURS) |[ ] [ ] [ ]
| DIDD 1915c Nutrition (DIDD NUTR) |[ ] [ ] [ ]
| DIDD 1915c Occupational Therapy (DIDD OT) |[ ] [ ] [ ]
| DIDD 1915c Orientation and Mobility\* (DIDD O&M) |[ ] [ ] [ ]
| DIDD 1915c Physical Therapy (DIDD PT)  |[ ] [ ] [ ]
| DIDD 1915c Speech, Language and Hearing (DIDD SLH) |[ ] [ ] [ ]
| DIDD 1915c Speech, Language and Hearing Assistive Technology (DIDD SLP) |[ ] [ ] [ ]
| **ANCILLARY SERVICES**  |
| DIDD 1915c Environmental Accessibility Modifications (DIDD EAM) |[ ] [ ] [ ]
| DIDD 1915c Personal Emergency Response System (DIDD PERS) |[ ] [ ] [ ]
| **ENABLING TECHNOLOGY SERVICES** |
| DIDD 1915c Enabling Technology (DIDD ETECH) |[ ] [ ] [ ]
| DIDD 1915c Specialized Medical Equipment Supplies and Assistive Technology (DIDD SMESAT) |[ ] [ ] [ ]
| **PERSONAL ASSISTANCE SERVICE** |
| DIDD 1915c Personal Assistance (DIDD PA) |[ ] [ ] [ ]
| **RESPITE SERVICES** |
| DIDD 1915c Respite (DIDD RESP) |[ ] [ ] [ ]
| DIDD 1915c Behavioral Respite (DIDD BA RESP) |[ ] [ ] [ ]
| **SUPPORT COORDINATION SERVICE** |
| DIDD 1915c Support Coordination (DIDD 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** |
| DIDD 1915c Individual Transportation (DIDD 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** |
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| **RESIDENTIAL SERVICES** |
| 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 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 CLS Behavioral Health Community Stabilization and Transition 2a (ECF CLS BHCST 2a) |[ ] [ ] [ ]
| ECF CLS Behavioral Health Community Stabilization and Transition 2b(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 SERVICES** |
| 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 (ECF EXPL) |[ ] [ ] [ ]
| ECF Job Coaching – Integrated, Competitive Employment (ECF JCICE) |[ ] [ ] [ ]
| ECF Job Coaching - Individual Self-Employment (ECF JCSE) |[ ] [ ] [ ]
| ECF Job Development Plan (ECF JDSEP) |[ ] [ ] [ ]
| ECF Self-Employment Plan |[ ] [ ] [ ]
| 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)  |[ ] [ ] [ ]
| 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) |[ ] [ ] [ ]
| **PERSONAL ASSISTANCE SERVICE** |
| ECF Personal Assistance (ECF PA) |[ ] [ ] [ ]
| ECF Supportive Home Care (ECF SHC) |[ ] [ ] [ ]
| **RESPITE SERVICE** |
| ECF Respite (ECF RESP) |[ ] [ ] [ ]
| **Enabling Technology SERVICE** |
| 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**

#####  The New provider credentialing application is for CHOICES applicants interested in providing services along with ANY OF THE FOLLOWING PROGRAM SERVICE: kATIE Beckett-A, Katie Beckett-B,1915C,AND/OR ecf choices

##### Should you wish to provide CHOICES as a stand-alone program, credentialing is conducted by the MCO. Therefore, CONTACT THE MCO FOR THEIR APPLICATION AND SUBMIT IT DIRECTLY TO THE MCO.

| **PROGRAM SERVICES** | **West** | **Middle** | **East** |
| --- | --- | --- | --- |
| **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 Assisted Care Living Facility (CH ACF) |[ ] [ ] [ ]
| **DAY SERVICE** |
| Choices Adult Day Care (CH ADC) |[ ] [ ] [ ]
| **Personal Assistance** **/ SUPPORTIVE HOME CARE – IN-HOME** |
| Choices Attendant Care (CH AC) |[ ] [ ] [ ]
| Choices Personal Care Visits (CH PCV) |[ ] [ ] [ ]
| **RESPITE SERVICE** |
| Choices Respite In-Home (CH RESP- IH) |[ ] [ ] [ ]
| **ANCILLARY SERVICES** |
| Choices Assistive Technology (CH AT) |[ ] [ ] [ ]
| Choices Minor Home Modifications (CH MHM) |[ ] [ ] [ ]
| Choices Personal Emergency Response System (CH PERS) |[ ] [ ] [ ]
| **ENABLING TECHNOLOGY** |
| Choices Enabling Technology (CH ETECH) |[ ] [ ] [ ]
| **OTHER SERVICES** |
| Choices Home-Delivered Meals (CH HDM) |[ ] [ ] [ ]
| Choices Pest Control (CH PC) |[ ] [ ] [ ]

|  |
| --- |
| SECTION 6: COUNTIES COVERED BY PROGRAM |

Select the counties and program(s) the applicant has the **capacity** to serve:

## PLEASE NOTE:

## **1915c & Katie Beckett – Part B** are credentialed and may be contracted for all counties and regions requested.

## **ECF/CHOICES/KB Part A** are credentialed for all counties requested. However, contracted counties are per MCO need.

**WEST REGION:** [ ]  **All Counties** [ ]  **n/a**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

**MIDDLE REGION:**  [ ]  **All Counties** [ ]  **n/a**

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

**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** |  |
| **CHOICES** |  |

# SUPPORTING DOCUMENTATION:

## Please see the didd website: [How to Become a Credentialed Provider (tn.gov)](https://www.tn.gov/didd/providers/provider-credentialing-application.html) for links to requirements (attachments 1-4) per service type and links to supplied documents.

## **Please see *Attachment 1- Credentialing Standards* for requirements per service type**

1. **Certificate of existence/authORization with an out of state business license:** This is only applicable to Enabling Technology providers outside of the State of Tennessee.
2. **Tennessee secretary of state registration:** Please submit documentation showing proof of active status with the Tennessee Secretary of State (where applicable) authorizing the agency to conduct business. *This information must align with the submitted Disclosure Form and tax forms.*
3. **Insurance Coverage QUOTES or valid certificate of insurance:** Please submit a quote detailing: *Coverage Description; Insurance Company & Policy Number; Exceptions and Exclusions; Policy Effective Date; Policy Expiration Date; Limit(s) of Liability; and Name and Address of Insured.*
	* + - 1. The insurer’s name must align with the submitted Tennessee Secretary of State, Disclosure Form, and tax forms.
				2. Only a QUOTE is required during the credentialing process.
				3. A valid Certificate of Insurance (COI) is **required** for each insurance type listed below before your contract may be activated.
				4. Please note coverages must meet the expressed requirements noted below:

**Types of policies and coverage:**

1. **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)**.
	* + *The Department will accept, for Service Agreement and Credentialling purposes, $1,000,000 in Automobile Liability Insurance, combined with an Umbrella Policy that has an additional $500,000 in coverage. An Umbrella Policy cannot substitute the required $1,000,000 Automobile Liability Insurance.*
2. **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 **$750,000.00 per occurrence** and **$1,500,000 aggregate.**
3. **Professional Malpractice Liability** coverage with a limit of not less than **$750,000** and **$1,500,000 aggregate.**
4. **Workers' Compensation/ Employers' Liability** (including all States’ coverage) with a limit not less than **$750,000 per occurrence** for employers’ liability.
5. **TAX FORMS:** Please submit the W-9 Form, Substitute W-9, and IRS 147c Form/Letter where applicable for your organization. *This information must align with the submitted Disclosure Form and the business name on the applicable Tennessee Secretary of State registration.*
6. **National Criminal Background Check:** A national criminal background check must be completed for the Chairperson of the Board, Owner(s), and Executive Director/Managing Employee.
7. The applicant should obtain the National Fingerprint-based Criminal History Record Check (FCHRC) no more than 60 calendar days prior tosubmission of the Provider Credentialing Application. *A national FCHRC obtained more than 60 calendar days of the submission of the Provider Credentialing Application will NOT be accepted.*
8. Please see the National Background Check FAQ for instructions on how to complete the national criminal background check.
9. Please see the instructions for Identogo.
10. **Volunteer and Criminal History System (VECHS) form:** To aid in the accurate completion of this form, the qualifying entity (DIDD) information/section has been completed.
	* Each of the following persons must submit the **VECHS form** **along with their receipt proof of completing their national background check**: owner(s), executive director, managing employee, and board chairperson (not-for-profit).
	* For the NONCRIMINAL JUSTICE APPLICANT’S PRIVACY RIGHTS (PRIVACY RIGHTS) document, please read prior to completion of your national criminal background check and retain a copy for agency files.
11. **RESUME FOR EXECUTIVE DIRECTOR**: Please submit a resume for the person slated for the Executive Director position as required, ensuring the person meets one of the following educational and experience requirements:

1. Bachelor’s Degree in a human service field (such as social work, psychology, education, nursing, or closely related field) and five (5) years of experience in service delivery to persons with intellectual/developmental disabilities, with at least two (2) of these years serving in a supervisory capacity.

2. An Associate’s Degree in nursing, education, or a related field and six (6) years of experience in service delivery to persons with intellectual/ developmental disabilities, with at least two (2) of these years serving in a supervisory capacity.

1. A Bachelor’s Degree in non-related human service fields with seven (7) years of experience in service delivery to person with intellectual/developmental disabilities, with at least four (4) of these years serving in a supervisory capacity.
2. Substitute Experience for Education: Ten (10) years of experience in service delivery to persons with intellectual/developmental disabilities, with at least four (4) of these years serving in a supervisory capacity.
3. Existing providers of ECF and CHOICES services contracted with MCOs requesting to expand are exempt from this requirement.
4. **ORGANIZATIONAL CHART:** Please submit an organizational chart which shows all agency participants (i.e., owner(s), board of directors/advisory board, executive director, management staff, human resources, direct support staff, housing manager(s), nurse(s), etc.). Ensure key operational positions and reporting structures are clearly demonstrated and your organizational chart and job descriptions coverage is provided as needed to deliver all required services.
5. **JOB DESCRIPTIONS**: Where indicated, please supply job descriptions showing job duties, education requirements and experience requirements. Job Descriptions must match title/positions on the Organizational Chart. The following responsibilities/functions must be noted in the job descriptions: Complaint Resolution, Reportable Event Management, Title VI, Staff Training, and Personal Funds Management (Rep Payee, if applicable).
6. **Proof of Financial Capacity:** These documents describe your understanding about service implementation and overall operations as it relates to DIDD and MCO(s).
7. **Projected Budget:** Submit forecast income statements (*projected budget*), based on the current Service Rate structure, for the initial six (6) months of operation. Please be sure to note each month separately showing growth of agency as needed. Address direct and Indirect operating costs including, but not limited to, the following:
	1. **Expenses**: employee salaries and other employee costs, facility costs, utilities, transportation, service contracts, administrative cost, workman’s compensation insurance, licensure fees, other support services, etc. *For employee salaries, please be sure to reflect coverage for the services and levels of need reported in calculations.*
	2. **Income**: Identify each specific service rate and level of need used. This must include each service requested. Your budget may also include other income such as SSI for residential services.
	3. **Summary of Budget Calculations:** Utilize the Available Service Rates for the current Fiscal Year (FY) document(s) for the applicable program(s) you are applying for when preparing your budget. Identify each specific service rate and level of need used when calculating your budget. Provide the number of persons used to calculate each service.
8. **Proof of Eligible Funds:** Submit a signed letter from a bank or lending institution showing proof of access to funds equal to or exceeding the initial six (6) months of the projected expenses. This includes operational reserves or a line of credit. This letter must show the account is in the name of the agency. Bank statements will not be accepted.
9. **Disclosure Form:**
	* + Any person or entity who owns five (5) percent or more of the business should be reported as an owner.
		+ Complete the entire form as instructed.
		+ Must have an assigned Tax ID number, National Provider Identifier (NPI), and Medicaid ID number.
		+ Must supply the name, full social security number (**please do not include the EIN in this section**), and date of birth for each owner, executive director/managing employee, and board chair.

1. This information is used by DIDD to check the following registries:  Office of Inspector General/Exclusion

data base (OIG LEIE), TN Department of Health Abuse Registry, TN Department of Correction Felony Offender Information (FOIL), National Sex Offender Public Website, SIRI, and Systems For Award Management (SAM). **PROVIDER ENTITIES**:  The provider Entity Federal Tax Id number and National Provider Identifier (NPI) number must be for an organization. *Business information must match what is reported on the TN Secretary of State registration. If applicable, W9 Form, IRS's147C form/letter, and application.*

1. **PROVIDER PERSON***:* The tax id number (TIN) and the NPI number must be for an individual. *Business*

*information must match what is reported on the TN Secretary of State registration. If applicable, W9 Form, IRS's147C form/letter, and application.*

1. **Home & Community-Based Services (HCBS) Settings Rule Self-Assessment:**
2. All applicable current and incoming providers are required to show a plan to comply with the Centers for Medicaid and Medicare Services (CMS) at the time of credentialing and ensure compliance monitoring is ongoing.
3. As a new provider you are answering questions related to future **and** current sites **and** how you plan to implement these Federal guidelines.
4. Please follow the instructions at the beginning and end of each tool when providing answers.
5. In the “evidence” section of the self-assessments, please note **the specific name of the policy or document** which shows where proof of your plan to comply may be found.
6. Please submit the following documentation to demonstrate how your agency will meet 100% compliance with the HCBS Settings Rule. This includes, but is not limited to the following:
* Employment application
* Lease
* Resident handbook
* Satisfaction survey
* Specific name of policy
* Tenant agreement
1. Please verify evidence is documented where indicated.
2. General statements in lieu of policy or document will not be accepted as proof of an intent to comply.

**FOR EXAMPLE**:

| **SAMPLE QUESTION** | **YES/NO** | **Required Evidence of Compliance with HCBS rules** |
| --- | --- | --- |
| Does the setting offer onsite services, such as day habilitation, medical, behavioral, therapeutic, social and or recreational services in a manner that comports with the HCBS Setting Rule? | Yes | “Rights Policy” states these services can be provided in the person’s home should they desire.  |
| Do all residents have a legally enforceable agreement with the setting landlord? | Yes | We are applying to provide supported living services and leases will be between the person and their landlord. However, we will inform them of their right to this legally enforceable agreement in the “Resident Handbook”.  |
| Does the setting offer the same responsibilities/protections from eviction for Medicaid recipients as all tenants under the Uniform Residential Landlord and Tenant Act?  | Yes | Please see the “resident handbook” which states the person will not be evicted should they decide to change provider agencies.  |
| Are cameras that are present inside the setting only utilized in direct relation to the person-centered plan of care? (Put N/A if no cameras are present in the setting) | N/A | Cameras will NOT be used, please see “HCBS policy” |
| Is there a curfew or other requirement for a scheduled return to the setting?  | NO | The “Rights Policy” shows the person will not be required to be at home or other location at a specific or scheduled time and no curfew is present.  |
| Are individuals receiving Medicaid HCBS facilitated in accessing amenities such as a pool or gym use by others on-site?  | Yes | The “Resident Handbook” states the person has the right to use any amenities such as pool or gym available at their residence (i.e., leased apartment building).  |

**a. TN Residential Provider Self-Assessment: Click** [**HERE**](https://www.tn.gov/content/dam/tn/didd/documents/providers/how-to/long-term-services-supports-coordination/TN_Residential_Provider_Self-Assessment.docx)

* Only **one** TN Residential Provider Self-Assessment is required for **all** residential services requested.
* **1915c Waiver Services:** *Family Model Residential Support, Medical Residential, Residential Habilitation, Semi-Independent Living, and Supported Living.*
* **ECF CHOICES:** *Community Living Supports (1a-4), Community Living Supports – Family Model (1a-4), Intensive Behavioral Community Transition and Stabilization Services, Community Stabilization and Transition, Behavioral Health Community Stabilization and Transition 2a & 2b, and Emergency Placement.*
* **CHOICES:** *Assisted Care Living Facility,**Community Living Supports (1-3), Community Living Supports – Family Model (1-3)*

**b: TN Non-Residential Provider Self-Assessment: Click** [**HERE**](https://www.tn.gov/content/dam/tn/didd/documents/providers/how-to/long-term-services-supports-coordination/TN_Non-Residential_Provider_Self-Assessment.docx)

* Only **one** TN Non-Residential Provider Self-Assessment is required for **all** non-residential services requested.
* **1915c Waiver Services:** *Community Participation Supports, Intermittent Employment & Community Integration Wrap-Around Supports, Non-Residential Homebound Support Services, and Supported Employment.*
* **ECF CHOICES**: *Community Integrated Support Services, Independent Living Skills Training, Supported Employment (Individual Employment Support and Small Group), Co-Worker Supports, Discovery, Exploration, Job Coaching, Job Development Plan, Self-Employment Plan, Job Development Startup, Self-Employment Startup, Situational Observation and Assessment, Integrated Employment Path Services, Employment Discovery and Customization, Career Advancement, and Benefits Counseling (CWIC, Self Employed or Provider Employed).*
* **CHOICES:** *Adult Day Care*
1. **Policies & PROCEDURES:**
* Providers are charged with writing policies which explain your plan of implementation and processes to monitor the Agency’s effectiveness/success.
* Please see ***ATTACHMENT 3- Provider Credentialing Policy Requirements*** for policy requirements per service type.
* **Please complete and submit the Minimum Required Policies & Review Guidelines Tool** :The critical elements in each policy are provided to aid the provider in developing standards and expectations to ensure health, safety, and accessibility. The provider must clearly demonstrate in each policy all critical elements, concepts, expectations, and outcomes. The tool is located at [How to Become a Credentialed Provider (tn.gov)](https://www.tn.gov/didd/providers/provider-credentialing-application.html)

# SECTION 7: STATEMENT OF UNDERSTANDING

**Is the executive director (managing employee), owner(s), and/or chairperson of the board a fiduciary for someone the agency intends to support? \* Yes** [ ]  **No** [ ]

\*If **YES**, complete the following Statement of Understanding below. If **NO**, this section should be left blank.

**The conservator will not receive payment as an employee or board member if the person is supported by the organization unless specifically permitted in the Order of Conservatorship. As the conservator of a person enrolled in any of the Medicaid Waivers, I hereby acknowledge I/we are aware that under federal guidelines I/we cannot be paid as an employee or board member for services provided and funded under the Medicaid Home and Community Based Services Waiver program. DIDD and/or the DIDD/MCO’s will monitor compliance to this federal statute. Consequences for non-compliance will include recoupment of funds used to pay the noted relatives, possible investigation of Medicaid fraud and disenrollment as a provider.**

**SIGNATURE SECTION**

|  |  |
| --- | --- |
| 1. Agency Name: | 2. Tennessee County: |
| 3. Name: | 4. Relation: |
| 5. Signature: | 6. Date: |
|  |
| 7. Name: | 8. Relation: |
| 9. Signature: | 10. Date: |
|  |
| 11. Name: | 12. Relation: |
| 13. Signature: | 14. Date: |

# SECTION 8: SERVICE DEFINITIONS AND IMPLEMENTATION

This 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 Credential Application, and to also attest to the truthfulness and accuracy of the information submitted. DIDD may terminate any potential provider from participation in the application process due to material misrepresentation or falsification of information.

**See Attachment 4 for the Program Service Definitions: I certify I have reviewed, understand, and agree to the service definitions and implementation requirements for Katie Beckett, 1915c Home and Community-Based Services (HCBS) waivers, and Employment and Community First (ECF)CHOICES and CHOICES as applicable to the service(s) selected on this application.**

[ ]  Katie Beckett-Part A

[ ]  Katie Beckett-Part B

[ ]  1915c

[ ]  ECF CHOICES

[ ]  CHOICES

**SIGNATURE SECTION**

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

# SECTION 9: 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 Credential Application, and to also attest to the truthfulness and accuracy of the information submitted. DIDD 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 B program, and/or ECF 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: |

# APPLICATION STATUS:

* 1. Your application will not move to the next step of the credentialing process until it and all required supporting documents are complete and accurate.
	2. Once the application is complete, the application will be reviewed by the Provider Development Committee (PDC).
	3. The applicant will be notified upon successful completion of the credentialing process.

# MERGERS AND ACQUISITIONS

When a change of ownership, merger and/or acquisition occurs, it is the provider’s responsibility to notify DIDD.

# DIDD revocation of credentialing application

The Department reserves the right to revoke credentialing of any application(s) including but not limited to the following reasons:

1. Evidence is discovered demonstrating material misrepresentation or falsification of information on the application.
2. Additional information is received or discovered indicating the Department erroneously credentialed the application (e.g., the Department discovered the applicant is listed on the LEIE exclusion list or one of the offender registries, etc.).

# additional notices

* DIDD reserves the right to request any information relevant to the provider credentialing process.
* Completion and acceptance of this credentialing application by DIDD is not a guarantee of MCO network participation.
* DIDD/MCO policies and procedures will govern appeals related to network participation *(if available).*