OMR Provider Qualification Pilot Program Application

1. CEO/Director: *(please print)*		**Date:**	
2. Provider Name *(if registered in HCSIS, use provider name in HCSIS)*:			
3. Mailing Address:			
4. Telephone #:			
5. Fax #:			
6. E-Mail Address:			
7. Is the provider name registered in HCSIS?		☐ Yes	☐ No
8. Length of time as provider of Waiver services			
☐ 0 (New Provider)	☐ Less Than 5 Years	☐ 5 To 10 Years	☐ More Than 10 Years
9. Type of provider *(check all that apply to Waiver services only)*:			
☐ For Profit	☐ Not-For Profit	☐ Government	
☐ Agency Providing Licensed and Unlicensed Services	☐ Agency Providing Unlicensed Services Only	☐ Individual Professional Providing Licensed Services	
☐ Agency Of Choice Intermediary Service Organization		☐ Family Member Provider	
10. Geographical area served *(check all that apply to Waiver services only)*:			
☐ Central PA	☐ Northeastern PA	☐ Southeastern PA	☐ Western PA
☐ Outside of PA	*State(s) served outside of Pennsylvania:*		
11. Number of people served in PA MR system through Waiver funding:			
12. Funding amount received from PA MR system in Fiscal Year 2004/2005 for Waiver services:			
13. Identify current Waiver services provided (include additional sheets as necessary):			

Thank you for your interest in volunteering for OMR's Provider Qualification Pilot Program.

Please send completed applications by May 15, 2006 via regular mail or e-mail to:

Beth Hovenstine
Health and Welfare Building, Room 413
PO Box 2675
Harrisburg, PA 17105-2675
E-mail: ra-omrproviderqualif@state.pa.us

Print Form

Submit by Email