### Home and Community Based Waiver Services
Provider Enrollment Information Form

**STEP 1:** Choose the Waiver/Program(s) that you are enrolling for.

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<tr>
<td>Aging</td>
<td>Attendant Care/ACT 150</td>
<td>COMMCARE</td>
<td>Independence</td>
<td>OBRA</td>
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</table>

**STEP 2:** Choose the service(s) you are enrolling for.

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**Does your agency provide complete care management and coordination for consumers?**

- [ ] YES
- [ ] NO

If yes, please select the service(s) that you want to provide below:

- [ ] Service Coordination
- [ ] Transition Service Coordination (Nursing Home Transition Partners only)

If this option is selected, no other service on this form can be chosen.

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**Do you have a Home Care Agency license from the Dept. of Health?**

- [ ] YES
- [ ] NO

If yes, please select the service(s) that you want to provide below:

- [ ] Personal Assistant Services (PAS)
- [ ] Personal Assistant Services (PAS) – Clustered Shared Living Arrangement (CSLA)
- [ ] Respite

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**Do you have a Home Health Agency license from the Dept. of Health?**

- [ ] YES
- [ ] NO

If enrolling as an individual ONLY, do you have a license from the Department of State for an individual specialty?

- [ ] YES
- [ ] NO

If yes, please select the service(s) that you want to provide below:

- [ ] Home Health Aide (Aging Waiver only)
- [ ] Home Health-Nursing (RN)
- [ ] Home Health-Nursing (LPN)
- [ ] Home Health-Nursing-Occupational Therapy
- [ ] Home Health-Occupational Therapy-Assistant
- [ ] Home Health-Occupational Therapy
- [ ] Home Health-Physical Therapy-Assistant
- [ ] Home Health-Physical Therapy
- [ ] Behavioral Therapy
- [ ] Cognitive Therapy
- [ ] Counseling Services
- [ ] Nutritional Counseling
- [ ] Personal Assistant Services (PAS)
- [ ] Respite
- [ ] Personal Assistant Services (PAS) – Clustered Shared Living Arrangement (CSLA)

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**Do you have an Adult Day Care License from Human Services or the Dept. of Aging?**

- [ ] YES
- [ ] NO

If yes, please select the service(s) that you want to provide below:

- [ ] Adult Daily Living
- [ ] Adult Daily Living Services Half Day
- [ ] Adult Daily Living Enhanced (must have the additional Enhanced agreement)
- [ ] Adult Daily Living Enhanced Half Day (must have the additional Enhanced agreement)

Please note that a provider may only choose Adult Daily Living or Adult Daily Living Enhanced – not both.

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**Does your agency specialize in services that assist consumers with obtaining new skills in order to be a part of their community?**

- [ ] YES
- [ ] NO

If yes, please select the services that you want to provide below:

- [ ] Career Assessment
- [ ] Job Coaching
- [ ] Job Finding
- [ ] Employment Skills
- [ ] Benefits Counseling
- [ ] Community Integration
**Does your agency specialize in a vendor service? YES ☐ NO ☐**

If yes, please select the service(s) that you want to provide below:

- ☐ Assistive Technology *(Drug and Device Certification from the Dept. of Health)*
- ☐ Community Transition Services
- ☐ Home Adaptations *(Contractor’s license if required by trade)*
- ☐ Home Delivered Meals *(Certification from the Dept. of Agriculture)*
- ☐ Non-Medical, Non-Emergency Transportation *(Public Utilities Commission license required)*
- ☐ Personal Emergency Response System (PERS) Installation and Maintenance
- ☐ Specialized Medical Equipment and Supplies *(Drug and Device Certification from the Dept. of Health)*
- ☐ Telecare Services *(Aging Waiver Only) (Home Health Agency License or Drug and Device Certification from Dept. of Health)*
- ☐ Vehicle Modifications *(Quality Assurance Program Accreditation by the National Mobility Equipment Dealers Association)*

**Has your agency achieved CARF Brain Injury Home and Community Services accreditation? YES ☐ NO ☐**

If yes, please select the service(s) that you want to provide below:

- ☐ Residential Habilitation in a 1-3 group setting
  - ☐ Res. Habilitation Supplemental for 1:1
  - ☐ Res. Habilitation Supplemental for 2:1

- ☐ Structured Day Habilitation-Group
  - ☐ Structured Day Supplemental for 1:1
  - ☐ Structured Day Supplemental for 2:1

These services are available in the COMMCARE and OBRA waivers only.

Supplemental Services cannot be selected without a corresponding group setting service.

**STEP 3: Choose the counties your agency is willing and able to provide services in.**

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**03/07/2017**
STEP 4: Please answer all of the following questions.

For 1915(c) Home and Community-Based waivers, settings that are **not** home and community based are defined at Federal Regulation 42 CFR 441.301(c)(5).

**Does your agency provide services in any of the following settings?**

1. Nursing Facility                   YES  NO
2. Institution for Mental Diseases   YES  NO
3. Public or Private ICF/ID          YES  NO
4. Hospital                          YES  NO

For 1915(c) Home and Community-Based waivers, settings that are **presumed** to have the qualities of an institution are defined at Federal Regulation 42 CFR 441.301(c)(5)(v).

**Does your agency provide services in a publicly or privately operated facility that provides inpatient institutional treatment?** YES  NO

**Does your agency provide services in a building on the grounds of, or immediately adjacent to, a public institution (A public institution is an inpatient facility that is financed and operated by a county, state, municipality, or other unit of government. A privately owned nursing facility is not a public institution.)** YES  NO

**Does your agency provide services in any of the following settings?**

1. Farmstead or disability-specific farm community YES  NO
2. Gated/secured community for people with disabilities YES  NO
3. Residential school                  YES  NO

**Do you own, rent/lease, or operate a residential setting (i.e. licensed or unlicensed) at this location where services are provided?** YES  NO
STEP 5:  Choose an effective date for the services to begin and sign below. Services cannot be backdated.

Requested effective date: ______________________

____________________________________________  _________________
Signature of Authorized Representative  Title

____________________________________________  __________________
Print Name  Date

____________________________________________________
Agency Name

____________________________________________
MPI # (PROMISe™)  Four Digit Service Location (PROMISe™)

____________________________
Service Location Address

**Please note:** One Provider Enrollment Information Form must be completed for each service location. This ensures that your agency’s information is processed efficiently and accurately.

Selection of waiver services does not indicate final approval. Services should not be provided until your agency is approved and the participant’s service plan has been updated to reflect your agency as the approved service provider. Qualifications for each service will be reviewed and approved at the time of enrollment. Please be sure to include a copy of all valid licenses.

Staff qualifications needed to provide that service can be found in each individual waiver. [http://www.dhs.state.pa.us/foradults/healthcaremedicalassistance/supportserviceswaivers/index.htm](http://www.dhs.state.pa.us/foradults/healthcaremedicalassistance/supportserviceswaivers/index.htm)