

**Ohio Department of Mental Retardation and Developmental Disabilities
Division of Community Services**

Provider Certification

SPECIALIZED MEDICAL ADAPTIVE/ASSISTIVE EQUIPMENT AND SUPPLIES

LEVEL ONE WAIVER APPLICATION

INDIVIDUAL PROVIDER

“ means a self-employed person who provides services under the HCBS Level I waiver and does not employ, either directly, or through a contract, anyone else to provide such services”.

Please review the information provided with this application packet and follow the instructions to ensure that all appropriate documentation is included. Failure to submit required documentation and/or properly complete this application will result in its return to the applicant without department action.

DEFINITION OF SPECIALIZED MEDICAL ADAPTIVE/ASSISTIVE EQUIPMENT AND SUPPLIES

“Specialized medical adaptive/assistive equipment and supplies” means those specialized medical equipment and supplies that include devices, controls, or appliances, specified in the individual’s ISP, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the state plan and shall exclude those items that are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design, and installation. The benefit limitation for this service, personal emergency response systems and environmental accessibility adaptations combined shall not exceed six thousand dollars over a three year period.

NAME	
ADDRESS	
CITY/STATE/ZIP	
COUNTY	
SOCIAL SECURITY NUMBER	
AREA CODE & TELEPHONE NUMBER	

Evidence that the applicant meets the following standards and requirements must be submitted with the application.

- 1) Submit documentation verifying experience in providing the service (documentation may consist of letters from previous customers, a resume outlining experience or contractor’s license).**
- 2) At least 18 years of age (provide proof of age, copies of one of the following: birth certificate, drivers’ license, Ohio ID card, passport)**
- 3) Completion of a Ohio Health Plan Provider Enrollment Application/Agreement - 6750 (attached)**
- 4) Completion of a Electronic Media Notification Form - ODJFS 6301 (attached)**
- 5) Completion of the Level I Waiver General Letter of Assurances (attached)**
- 6) Completion of the W-9 Tax Payer Identification form (attached)**

Certified providers of specialized medical adaptive/assistive equipment and supplies services shall assure that:

- a) The individual meets all applicable state and local regulations that apply to the operation of the business or trade.
- b) The individual shall not agree to provide services to any individuals whose needs the applicant cannot meet.
- c) The individual shall implement environmental accessibility adaptations services in accordance with the ISP.
- d) The individual shall not provide environmental accessibility adaptations to his/her minor child (under eighteen) or to his/her spouse.
- e) The individual provider will adhere to continuing certification requirements as outlined in OAC 5123:2-8-08.

Signature indicates understanding and compliance of these assurances as part of participation in the Level I Waiver.

Signature of Applicant

Date

This application must be signed in the presence of and notarized by a notary public.

I hereby swear and affirm that the answers I have given and the statements I have made in this application are complete and true to the best of my knowledge and belief.

Signature of Applicant

Subscribed and duly sworn to before me according to law by the above-named applicant, this ____ day of _____, 20____ at County of _____, State of _____.

Notary Stamp or Seal

Signature of Notary Public

**RETURN COMPLETED APPLICATION WITH ANY SUPPORTING
DOCUMENTATION TO:
Ohio Department of MRDD
PROVIDER CERTIFICATION
30 E. BROAD STREET, 12TH FLOOR
COLUMBUS, OHIO 43215-2541**