

## APPLICATION FOR SUPPORTED LIVING/ HCBS WAIVER PROVIDER CERTIFICATION

This form must be completed by all applicants for provider certification. Additional forms are required for the specific Home and Community-Based Services (HCBS) waiver services that the applicant intends to provide to individuals enrolled on the Individual Options (IO) and Level One (L1) waivers. We cannot process your application until we have received this form, including all supporting documentation.

<input type="checkbox"/> I am applying for Independent Provider certification (i.e., I am a self-employed person who intends to provide services and shall not employ, either directly or through contract, anyone else to provide the services). <p style="text-align: center;"><b>OR</b></p> <input type="checkbox"/> I am applying for Agency Provider certification (i.e., I am the Chief Executive Officer [CEO] of an entity that employs persons for the purpose of providing services). Check the statement below which describes your agency. <ul style="list-style-type: none"> <li><input type="checkbox"/> I represent a small agency (i.e., one that serves or plans to serve 50 or fewer individuals).</li> <li style="text-align: center;"><b>OR</b></li> <li><input type="checkbox"/> I represent a large agency (i.e., one that serves or plans to serve 51 or more individuals).</li> </ul>
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<input type="checkbox"/> I am applying for initial certification. <p style="text-align: center;"><b>OR</b></p> <input type="checkbox"/> I am applying for renewal certification. <p style="text-align: center;"><b>OR</b></p> <input type="checkbox"/> I am applying to add additional HCBS waiver service(s) to term of existing certification.
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NAME OF INDEPENDENT/AGENCY PROVIDER	
NAME OF CEO OF AGENCY PROVIDER, IF APPLICABLE	
STREET ADDRESS	
CITY/STATE/ZIP	
COUNTY	
SOCIAL SECURITY NUMBER OF INDEPENDENT PROVIDER OR TAX ID NUMBER OF AGENCY PROVIDER	
AREA CODE & TELEPHONE NUMBER	
EMAIL ADDRESS	

I am applying for certification to provide non-waiver services.

Counties in which services will be delivered.

I am applying for certification to provide HCBS waiver services and am submitting an application addendum for the following services. Please check all that apply.

HCBS Waiver Services	Counties in which services will be delivered.
<input type="checkbox"/> Adaptive and Assistive Equipment (IO waiver only)	

HCBS Waiver Services	Counties in which services will be delivered.
<input type="checkbox"/> Adult Day Support & Vocational Habilitation	
<input type="checkbox"/> Adult Foster Care (IO waiver only)	
<input type="checkbox"/> Environmental Accessibility Adaptations	
<input type="checkbox"/> Home-Delivered Meals (IO waiver only)	
<input type="checkbox"/> Homemaker/Personal Care	
<input type="checkbox"/> Informal Respite (L1 waiver only)	
<input type="checkbox"/> Institutional Respite	
<input type="checkbox"/> Interpreter (IO waiver only)	
<input type="checkbox"/> Non-Medical Transportation to access adult day services	
<input type="checkbox"/> Nutrition (IO waiver only)	
<input type="checkbox"/> Personal Emergency Response Systems (L1 waiver only)	
<input type="checkbox"/> Social Work (IO waiver only)	
<input type="checkbox"/> Specialized Medical Equipment and Supplies (L1 waiver only)	
<input type="checkbox"/> Supported Employment-Community & Supported Employment-Enclave	
<input type="checkbox"/> Transportation (L1 waiver only)	
<input type="checkbox"/> Transportation Mileage other than to access adult day services (IO waiver only)	

**Each independent provider and each CEO of an agency provider must submit evidence of the following standards upon application. Please check the box to indicate that the documentation is included.**

- Be at least 18 years of age
- Hold a high school diploma or GED (except for persons who held provider certification or were employed by a certified agency provider on September 30, 2009)
- Have a valid Social Security Number
- Have a State of Ohio identification, a valid driver's license, or other government-issued photo identification
- Have a current report from the Bureau of Criminal Identification and Investigation (BCII) which demonstrates he/she has not been convicted of or pleaded guilty to any of the offenses listed in division (E) of section 5126.28 of the Ohio Revised Code; a criminal record check by the Federal Bureau of Investigation is required for those who cannot present proof that they have been residents of Ohio for the five-year period prior to the date of the background investigation

**Agency providers do not need to submit this information for each employee, contractor, and employee of a contractor upon application, but must maintain evidence of compliance with these standards.**

**Each independent/agency provider must meet the following requirements. Please initial to indicate your understanding and assurance to comply.**

- \_\_\_\_\_ Meet the requirements of rule 5123:2-2-01 (*Provider Certification*) of the Ohio Administrative Code and other standards and assurances established under Chapter 5123. of the Ohio Revised Code and division 5123:2 of the Ohio Administrative Code for the specific service(s) to be provided
- \_\_\_\_\_ Maintain a current mailing address on file with the Department

**Each independent provider and each CEO of an agency provider must meet the following requirement. Please initial to indicate your understanding and assurance to comply.**

- \_\_\_\_\_ Report in writing to the Department, within 14 calendar days, if he/she is ever formally charged with, convicted of, or pleads guilty to any of the offenses listed in division (E) of section 5126.28 of the Ohio Revised Code

**Each independent provider; each CEO of an agency provider; and each employee, contractor, and employee of a contractor of an agency provider who is engaged in a direct services position must meet the following requirements. Please initial to indicate your understanding and assurance to comply.**

- \_\_\_\_\_ Not be listed on the Abuser Registry established pursuant to sections 5123.50 to 5123.54 of the Ohio Revised Code

- \_\_\_\_\_ Not be listed on the Nurse Aide Registry indicating that the Ohio Department of Health has made a determination of abuse, neglect, or misappropriation of property of a resident of a long-term care facility or residential care facility
- \_\_\_\_\_ Be able to read, write, and understand English at a level sufficient to comply with all requirements set forth in administrative rules governing the services provided
- \_\_\_\_\_ Be able to effectively communicate with the individual receiving services
- \_\_\_\_\_ Provide services only to individuals whose needs he/she can meet
- \_\_\_\_\_ Implement services in accordance with the ISP
- \_\_\_\_\_ Take all reasonable steps necessary to prevent the occurrence or reoccurrence of incidents adversely affecting the health and safety of individuals served
- \_\_\_\_\_ Comply with the requirements of behavior supports established under rules adopted by the department
- \_\_\_\_\_ Ensure that anyone responsible for implementing behavior support plans receives training in the plan components prior to implementation of the plans
- \_\_\_\_\_ Arrange for substitute coverage, if necessary, only from a provider certified by the department and as identified in the individual's ISP, notify the individual or legally responsible person(s) in the event that substitute coverage is necessary, and notify the person identified in the ISP when substitute coverage is not available
- \_\_\_\_\_ Notify, in writing, the individual or the individual's guardian and the individual's service and support administrator in the event that the provider intends to cease providing services to the individual no less than 30 calendar days prior to termination of services
- \_\_\_\_\_ Annually complete training in the provisions of rights of individuals set forth in sections 5123.62 to 5123.64 of the Ohio Revised Code and the requirements of rule 5123:2-17-02 (*Incidents Adversely Affecting Health and Safety*) of the Ohio Administrative Code
- \_\_\_\_\_ Not provide services to his/her minor child (under age 18) or to his/her spouse
- \_\_\_\_\_ Not engage in sexual conduct or have sexual contact with an individual for whom he/she is providing care
- \_\_\_\_\_ Not administer any medication to or perform health care tasks for individuals who receive services unless he/she meets applicable requirements of Chapters 4723., 5123., and 5126. of the Ohio Revised Code and rules adopted under those chapters

**Each agency provider must submit evidence that the applicant employs a CEO who has:**

- At least one year of full-time, paid work experience in the provision of services to individuals with developmental disabilities which included responsibility for personnel matters, supervision of employees, program services, and financial management
- A Bachelor's degree from an accredited institution or at least four years of full-time, paid work experience as a supervisor of programs or services for individuals with developmental disabilities

**Each agency provider must submit written policies and procedures that address the agency's management practices regarding:**

- Principles of individuals' self-determination
- Confidentiality of individuals' records
- Safeguarding individuals' funds
- Incident reporting and investigation
- Individuals' satisfaction with services delivered
- Internal monitoring and evaluating procedures to improve services delivered
- Supervision of staff
- Staff training plan
- Annual written notice to employees and contractors explaining conduct for which someone may be placed on the Abuser Registry and setting forth the requirement to report if he/she is ever formally charged with, convicted of, or pleads guilty to any of the offenses listed in division (E) of section 5126.28 of the Ohio Revised Code

**Each agency provider must meet the following requirement. Please initial to indicate your understanding and assurance to comply.**

- \_\_\_\_\_ At a frequency of at least once every three years, the CEO and each employee, contractor, and employee of a contractor who is engaged in a direct services position shall undergo a background check by BCII which demonstrates that he/she has not been convicted of or pleaded guilty to any of the offenses listed in division (E) of section 5126.28 of the Ohio Revised Code

Applications for provider certification (except for the following HCBS waiver services which are not subject to an application fee: Adaptive and Assistive Equipment, Environmental Accessibility Adaptations, Home Delivered Meals, Interpreter, Nutrition, Personal Emergency Response Systems, Social Work, and Specialized Medical Equipment and Supplies) must include the appropriate application fee. Application fees must be submitted in the form of a cashier's check, corporate check, or money order, payable to Treasurer State of Ohio. Payment in full is required at the time of application. Applications submitted without a check or money order will be returned to the applicant.

	Initial Certification (1 year)	Renewal Certification (3 years)	Add Service(s) During Term of Certification
Independent Provider or Family Consortium	\$ 50	\$ 100	\$ 15
Small Agency Provider (serving 50 or fewer individuals)	\$ 300	\$ 800	\$ 50
Large Agency Provider (serving 51 or more individuals)	\$ 700	\$ 1,600	\$ 100

**Application fees are non-refundable. If you are uncertain about which fee applies, contact the Provider Certification Unit at [provider.certification@dmr.state.oh.us](mailto:provider.certification@dmr.state.oh.us) before submitting your application.**

I have submitted the evidence as requested, understand the requirements, and certify that I will meet the above initialed assurances. I understand that misrepresentation or falsification of this application or any supporting documentation may result in denial or revocation of provider certification.

\_\_\_\_\_  
Signature of independent provider/agency CEO applicant

\_\_\_\_\_  
Date

**Return completed application with supporting documentation to:**

Ohio Department of Developmental Disabilities  
Accounts Receivable  
30 East Broad Street, 13<sup>th</sup> Floor  
Columbus, Ohio 43215  
1-877-289-3636

Or email [Provider.Certification@dmr.state.oh.us](mailto:Provider.Certification@dmr.state.oh.us)