Alabama Department
of Mental Health
connecting mind and wellness

ID/LAH WAIVER SERVICE PROVIDER/VENDOR INITIAL APPLICATION

ADMH-DD

DIVISION OF DEVELOPMENTAL DISABILITIES

REVISED 10/01/2023

ENROLLMENT FORMS INCLUDED IN THIS PACKET:

- **Prospective Provider/Vendor Letter**
- **Waivers and Services**
- **Medicaid Provider Agreement**
- **Medicaid Provider Disclosure Form – *Complete one for EACH applicable individual indicated in first section of Disclosure form***
- **Form W-9 (Not a fillable form. Access fillable form on IRS website)**
- **Provider Contact / Location Information**
- **Immigration Status Attestation**
- **Revolving Door Attestation**
- **Assurance of Registration with Alabama Department of Revenue**
- **Certificate of Compliance with Drug-Free Workplace Requirements**
- **Certificate of Compliance with Drug-Free Workplace Practices**
- **Assurance of Compliance with all Federal Statutes Relating to Nondiscrimination**
- **Applicant Checklist**

INSTRUCTIONS:

1) Complete enrollment forms by typing or printing legibly using black ink only.
2) Complete a Provider Disclosure Form for ***each*** applicable individual, ***as indicated in the first section of the Disclosure Form***.
3) Complete one copy of each of the remaining forms.
4) Add NPI Registration Print Out (If our agency does not already have a Provider NPI number, register at https://nppes.cms.hhs.gov)
5) Make a copy of the application for your files.
6) Send the original, signed, application to:
   Alabama Department of Mental Health
   ATTN: LaToya Woods
   RSA Union Building
   100 North Union Street
   Suite 486
   Montgomery, AL 36104
   Or scan and email signed application to:
   latoya.woods@mh.alabama.gov

STATE OF ALABAMA
DEPARTMENT OF MENTAL HEALTH
RSA UNION BUILDING
100 NORTH UNION STREET
POST OFFICE BOX 301410
MONTGOMERY, AL 36130-1410
WWW.MH.ALABAMA.GOV

Kay Ivey
Governor

Kimberly G. Boswell
Commissioner

Dear Prospective Service Provider/Vendor:

The attached application is for potential waiver service providers who are not certified by the Alabama Department of Mental Health, Division of Developmental Disabilities (ADMH/DD). In addition, this application is for businesses that are vendors of waiver-covered items such as Assistive Technology, Specialized Medical Supplies (SMS), Home Modifications, Environmental Accessibility Adaptations (EAA), Speech and Language Therapy, Occupational Therapy, Physical Therapy, and Remote Support services desiring to partner with ADMH/DD. Please complete the attached application it in its entirety, noting requirements as detailed on the application cover page. Carefully read all documents and complete/sign where indicated. Any applicable certification(s) and/or professional license(s) must accompany the application.

The application must be returned to the address below: LaToya Woods, Provider Network Manager
Alabama Department of Mental Health
Division of Developmental Disabilities
RSA Union Building
I 00 North Union Street, Suite 486
P.O. Box 301410 Montgomery, AL 36130-1410

Or emailed to latoya.woods@mh.alabama.gov.

Once your business is enrolled as a Medicaid provider, you will be notified. You will also receive additional information regarding service delivery requirements. Medicaid enrollment does not authorize you to initiate services, but it does establish a payee number for waiver services indicated in your application. Your business may begin service/product provision but only after receipt of specific authorization requesting service(s)/product(s) are received from the support coordinator. The authorization should give the service(s)/product(s) requested, the date coverage begins, and the amount of money authorized for the service(s)/product(s). Services/products provided prior to receipt of the auth01ization will not be reimbursed.

Once the application is approved you will receive a Waiver Provider Manual which explains in more detail the provider requirements for record documentation and auditing.

If there are any questions, feel free to contact the Provider Network Manager at 334-353-1997.

Sincerely,

Kathy Sawyer
ADMH/DDD Associate Commissioner

ALABAMA DEPARTMENT OF MENTAL HEALTH
DIVISION OF DEVELOPMENTAL DISABILITIES
WAIVER SERVICE PROVIDER/VENDOR APPLICATION

WAIVER SERVICES REQUESTED FOR APPROVAL

Instructions:

Complete the check boxes for each waiver, and for each service within the respective waiver(s), to be considered for approval under this application.

Refer to the respective waiver documents Intellectual Disabilities Waiver (ID), Living at Home Waiver (LAH) as published on the ADMH website for additional information relative to waivers and waiver services.
https://mh.alabama.gov/community-waiver-program/
https://mh.alabama.gov/division-of-developmental-disabilities/systems-management/

WAIVER		SERVICE(S)			
CWP		Billing Code		SERVICE	Qualifications
☐	CWP	☐	T2029	Assistive Technology and Adaptive Aids Assessment and/or Training - CWP	Must meet all applicable state (Alabama Board of Home Medical Equipment Services Providers) and local licensure requirements.
		☐	T2029:SE	Assistive Technology and Adaptive Aids Devices - CWP	Must meet all applicable state (Alabama Board of Home Medical Equipment Services Providers) and local licensure requirements.
		☐	97535	Occupational Therapy	Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense. • Occupational Therapists are licensed under the Code of Alabama, 1975 Sec. 34-39-5.
		☐	97110	Physical Therapy	Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense. • Physical Therapists are licensed under the Code of Alabama, 1975 Sec.34-24-212.
		☐	H2019	Positive Behavorial Supports	Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation or any felony offense. • Physical Therapists are licensed under the Code of Alabama, 1975 Sec.34-24-212. See additional information pg. 26
		☐	92507	Speech and Language Therapy	Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation

				or any felony offense. • Speech Therapists are licensed under the Code of Alabama, 1975 Sec. 34-28A-1, Ch. 870-x-1-7.

WAIVER ID WAIVER	SERVICE(S) Billing Code	SERVICE	Qualifications
	97535:UC	Occupational Therapy	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Has not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, and communications with Support Coordinator Limits on service apply
	S5165:UC	Environmental Accessibility Adaptations	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Has not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include: Participant demographics, detailed quote for the service, communications with Support Coordinator Limited to $5000.00 per year per waive participants.
	T2029:UC	Assistive Technology	Licensed by the State of Alabama Meet all Code of Alabama Requirements Liability Insurance at least $1 million dollars Has not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator Limited to $5000.00 per year per waiver participant.
	S5160:UC	Personal Emergency Response System (Initial)	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator
	97110:UC	Physical Therapy	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator. Service limitations apply
	T1028:UC:U7	Remote Supports -	Recognized and experienced vendor in remote support technology with experience in at least 2 other states Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics,

				assessments, evaluations and communications with the support coordinator
	☐	H2019:UC	Positive Behavior Supports 1-3	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator *Special Qualifications apply per level provided. See attached pg 26
	☐	T2028:UC	Specialized Medical Supplies	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator Limited to $1800,00 per year per participant
	☐	92507:UC	Speech and Language Therapy	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator Service limitations apply

WAIVER	SERVICE(S)			
LAH	Billing Code		SERVICE	QUALIFICATIONS
LAH ☐	☐	S5165:UD	Environmental Accessibility Adaptations	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator
	☐	97535:UD	Occupational Therapy	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator
	☐	97110:UD	Physical Therapy	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator
LAH WAIVER	☐	T1028:UD:U7	Remote Supports	Recognized and experienced vendor in remote support technology with experience in at least 2 other states Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator
	☐	H2019:UD	Positive Behavioral Supports	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator ***Special Qualifications Apply per level provided. See attached pg 26
	☐	T2028:UD	Specialized Medical Supplies	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator
	☐	92507:UD	Speech and Language Therapy	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver

				Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator
	☐	S5160:UD	Personal Emergency Response System (Initial)	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator
	☐	T2029:UD:	Assistive Technology	Licensed by the State of Alabama Liability Insurance at least $1 million dollars Have not been debarred by OIG, SAMS, DUNS or AMA Must pass a background screen Must provide services in accordance with the waiver Keep records for all waiver participants that include RX from the participant's physician, Participant demographics, assessments, evaluations and communications with Support Coordinator

Select purpose of form below:

☒ **Initial Enrollment** PROVIDER AGREEMENT Revised 10/19/18

ATN # Not Applicable ADMH Application **NPI #** Click or tap here to enter text.

PROVIDER AGREEMENT

Name of Provider:_____

As a condition for participation as a provider under the Alabama Medicaid Program (MEDICAID), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 Agreement and Documents Constituting Agreement.

A copy of the current *Alabama Medicaid Provider Manual* and the *Alabama Medicaid Administrative Code* has been or will be furnished to the Provider. This Agreement is deemed to include the applicable provisions of the State Plan, *Alabama Medicaid Administrative Code*, and *Alabama Medicaid Provider Manual*, as amended, and all State and Federal laws and regulations. If this Agreement is deemed to be in violation of any of said provisions, then this Agreement is deemed amended so as to comply therewith. Invalidity of any portion of this Agreement shall not affect the validity, effectiveness, or enforceability of any other provision. Provider agrees to comply with all of the requirements of the above authorities governing or regulating MEDICAID. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the above authorities.

1.2 State and Federal Regulatory Requirements.

1.2.1 Provider has not been excluded or debarred from participation in any program under Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. § 1320a-7), or Executive Order 12549. Provider also has not been excluded or debarred from participation in any other state or federal health-care program. Provider must notify MEDICAID or its agent within ten (10) business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B), which could result in exclusion from the Medicaid program

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B, and provide such information on request to MEDICAID, the Alabama Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current by informing MEDICAID or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, or provider business addresses, at least thirty (30) business days prior to making such changes. Provider also agrees to notify MEDICAID or its agent within ten (10) business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must provide to MEDICAID complete information related to any such suspension or restriction.

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. As required by 42 C.F.R. §431.107, Provider agrees to keep any and all records necessary to disclose the extent of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. Provider also agrees to provide, on request, access to records required to be maintained under 42 C.F.R. §431.107 and copies of those records free of charge to MEDICAID, its agent, the Alabama Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. All such records shall be maintained for a period of at least three years plus the current year. However, if audit, litigation, or other action by or on behalf of the State of Alabama or the Federal Government has begun but is not completed at the end of the above time period, or if audit findings, litigation, or other action has not been resolved at the end of the above time period, said records shall be retained until resolution and finality thereof.

1.2.4 The Alabama Attorney General's Medicaid Fraud Control Unit, Alabama Medicaid Investigators, and internal and

external auditors for the state/federal government and/or MEDICAID may conduct interviews of Provider employees, subcontractors and its employees, witnesses, and recipients without the Provider's representative or Provider's legal counsel present unless the person voluntarily requests that the representative be present. Provider's employees, subcontractors and its employees, witnesses, and recipients must not be coerced by Provider or Provider's representative to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied with, in the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control cooperate fully in any investigation conducted by the Alabama Attorney General's Medicaid Fraud Control Unit and/or MEDICAID. Subcontractors are those persons or entities who provide medical goods or services for which the Provider bills the Medicaid program or who provide billing, administrative, or management services in connection with Medicaid-covered services.

1.2.5 Provider must not exclude or deny aid, care, service or other benefits available under MEDICAID or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid recipients in the same manner, by the same methods, and at the same level and quality as provided to the general public.

1.2.6 Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records.

1.2.7 Under no circumstances shall any commitments by MEDICAID constitute a debt of the State of Alabama as prohibited by Article XI, Section 213, Constitution of Alabama of 1901, as amended by Amendment 26. It is further agreed that if any provision of this Agreement shall contravene any statute or Constitutional provision or amendment, whether now in effect or which may, during the course of the Agreement, be enacted, then that conflicting provision in the Agreement shall be deemed null and void. The Provider's sole remedy for the settlement of any and all disputes arising under the terms of this Agreement shall be limited to the filing of a claim against Medicaid with the Board of Adjustment for the State of Alabama.

1.2.8 In the event litigation is had concerning any part of this Agreement, whether initiated by Provider or MEDICAID, it is agreed that such litigation shall be had and conducted in either the Circuit Court of Montgomery County, Alabama, or the United States District Court for the Middle District of Alabama, Northern Division, according to the jurisdiction of those respective courts. This provision is not intended to, nor shall it operate to, enlarge the jurisdiction of either of said courts, but is merely an agreement and stipulation as to venue.

1.3 Claims and Encounter Data

1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by MEDICAID, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true, accurate, complete, and that such information can be verified by source documents from which data entry is made by the Provider. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and/or federal laws.

1.3.2 Provider must submit encounter data required by MEDICAID or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement.

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with MEDICAID rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the *Alabama Medicaid Provider Manual*, and within the time limits established by MEDICAID for submission of claims. Claims for payment or encounter data submitted by the provider to a managed care entity or MEDICAID are governed by the Provider's contract with the managed care entity. Provider understands and agrees that MEDICAID is not liable or responsible for payment for any Medicaid-covered services provided under the managed care Provider contract, or any agreement other than this Medicaid Provider Agreement.

1.3.4 Federal and state law prohibits Provider from charging a recipient or any financially responsible relative or representative of the recipient for Medicaid-covered services, except where a copayment is authorized under the Medicaid State Plan. (42 C.F.R. §447.20). The provider (or its staff) must advise each recipient when MEDICAID payment will not be accepted prior to services being rendered, and the recipient must be notified of responsibility for the bill. The fact that Medicaid payment will not be accepted must be recorded in the recipient's medical record.

1.3.5 As a condition for eligibility for Medicaid benefits, a recipient assigns all rights to recover from any third party or any other source of payment to MEDICAID (42 C.F.R. §433.145 and §22-6-6.1, Code of Alabama 1975). Except as provided by MEDICAID's third-party recovery rules *(Alabama Medicaid Administrative Code*, Chapter 20),

Provider agrees to accept the amounts paid under MEDICAID as payment in full for all covered services. (42 C.F.R. §447.15).

1.3.6 Provider must refund to MEDICAID any overpayments, duplicate payments, and erroneous payments which are paid to Provider by MEDICAID as soon as the payment error is discovered.

1.3.7 Provider has an affirmative duty to verify that claims and encounters are received by MEDICAID or its agent and implement an effective method to track submitted claims against payments made by MEDICAID.

1.3.8 MEDICAID'S obligation to make payments hereunder is subject to the availability of State and Federal funds appropriated for MEDICAID purposes. Further, MEDICAID'S obligation to make payments hereunder is and shall be governed by all applicable State and Federal laws and regulations. In no event shall the MEDICAID payment exceed the amount charged to the general public for the same service.

1.3.9 Provider shall not charge MEDICAID for services rendered on a no-cost basis to the general public.

1.3.10 Provider is prohibited from offering incentives (such as discounts, rebates, refunds, or other similar unearned gratuity or gratuities) other than an improvement(s) in the quality of service(s), for the purpose of soliciting the patronage of MEDICAID recipients. Should the Provider give a discount or rebate to the general public, a like amount shall be adjusted to the credit of MEDICAID on the MEDICAID claim form, or such other method as MEDICAID may prescribe. Failure to make a voluntary adjustment by the Provider shall authorize MEDICAID to recover same by then existing administrative recoupment procedures or legal proceedings.

1.3.11 Provider agrees and hereby acknowledges that payments made under this agreement are subject to review, audit adjustment and recoupment action. In the event that Provider acquires or has acquired ownership of another MEDICAID provider through transfer, sale, assignment, merger, replacement or any other method, whether or not a new Agreement is required, Provider shall be responsible for any unrecovered improper MEDICAID payments made to the previous provider. An indemnification agreement between Provider and the previous provider shall not affect MEDICAID'S right to recovery.

1.3.12 Provider agrees to comply with the provisions of the *Alabama Medicaid Provider Manual* regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to MEDICAID or its agent are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detection and correcting all claims errors. If Provider contracts with third parties to provide claims and/or eligibility verification data from MEDICAID, the Provider remains responsible for verifying and validating all transactions and claims, and ensuring that the third party adheres to all client data confidentiality requirements.

II. RECIPIENT RIGHTS

2.1. Provider must maintain the recipient's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.

2.2. The recipient must have the right to choose providers unless that right has been restricted by MEDICAID or by waiver of this requirement from CMS. The recipient's acceptance of any service must be voluntary.

2.2.1 The recipient must have the right to choose any qualified provider of family planning services.

III. ADVANCE DIRECTIVES - HOSPITAL, HOME HEALTH, HOSPICE, AND NURSING HOME PROVIDERS

3.1 The provider shall comply with the requirements of §1902(w) of the Social Security Act (42 USC §1396a(w)) as described below:

3.1.1 Maintain written policies and procedures in respect to all adult individuals receiving medical care by or through the provider about patient rights under applicable state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

3.1.2 Provide written information to all adult individuals on patient policies concerning implementation of such rights;

3.1.3 Document in the patient's medical record whether or not the individual has executed an advance directive;

3.1.4 Not condition the provision of care or otherwise discriminate against a patient based on whether or not he/she has executed an advance directive;

3.1.5 Ensure compliance with requirements of state law (whether statutory or recognized by the courts) concerning

advance directives;

3.1.6 Provide (individually or with others) for education for staff and the community on issues concerning advance directives; and

3.1.7 Furnish the written information described above to adult individuals as required by law.

IV. TERM, AMENDMENT, AND TERMINATION

This Agreement will be effective from the date all enrollment documentation has been received and verified until the date the Agreement is terminated by either party. This Agreement may be amended as required, provided such amendment is in writing and signed by both parties concerned. Either party may terminate this Agreement by providing the other party with fifteen (15) days written notice. MEDICAID may immediately terminate the Agreement for cause if the Provider is excluded from the Medicare or Medicaid programs for any reason, loses its licenses or certificates, becomes ineligible for participation in the Medicaid program, fails to comply with the provisions of this Agreement, or if the Provider is or may be placing the health and safety of recipients at risk. MEDICAID may terminate this Agreement without notice if the Provider has not provided services to Medicaid recipients in excess of five (5) claims or

$100.00 during the last fiscal year.

V. CIVIL RIGHTS COMPLIANCE

Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990, Section 1557 of the Patient Protection and Affordable Care Act of 2010, and the Regulations issued thereunder by the Department of Health and Human Services (45 CFR Parts 80, 84, and 90) no individual shall, on the ground of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or services by this institution.

VI. SIGNATURE AUTHENTICATION STATEMENT

To the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to Medicaid's fiscal agent and the Alabama Medicaid Agency for the purpose of enrolling with Alabama Medicaid.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency of any and all records concerning provider, including, but not limited to, employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program.

Signature of applicant (or an authorized representative if you are enrolling as a provider group/supplier)

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who in any matter within jurisdiction of any depart or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious of fraudulent statement or entry.

Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. § 3571 Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against an individual who "knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under a Federal health care program. **The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.**

3. The Civil False Claims Act, 31 U.S.C. § 3729 imposes civil liability, in part, on any person who:

a) knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;

b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or

c) conspire to defraud the Government by getting a false or fraudulent claim allowed or paid.

4. Section 1128B(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United

States, or of any department or agency thereof, or of any State agency.

A claim that the Secretary determines is for a medical or other item or service that the person knows or should know:

a) was not provided as claimed; and/or

b) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to $10,000 per each item or service, an assessment of up to 3 times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The Government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment." **Remedies include compensatory and punitive damages, restitution and recovery of the amount of the unjust profit.**

Provider Representative Signature _____
(Must be an original signature)

Date. _____

Printed Name of Provider Representative: _____

Select purpose of form below: DISCLOSURE FORM Revised 12/09/16

X Initial Enrollment

ATN # NA – **Not Applicable – ADMH Application**

PROVIDER DISCLOSURE FORM

Providers who operate as a corporation, organization, institution, agency, partnership, professional association, or similar entity must complete the following information for each of the following individuals: (Print/Make additional copies as necessary)

Owners	Officers	Shareholders with 5% or more controlling interest
Agents	Directors	Managing Employees

This form must be completed for anyone who holds one of the above listed positions. Completion of this form requires that a valid answer be provided to EVERY question. Incomplete forms will be returned for the missing information.

The completion of this form is required to establish a new group or payee or update an enrolled group or payee. Please note that the address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Attach additional sheets if necessary.

Name:	Title:
Home Address:	Business Address:
Social Security Number:	Employer's Tax ID:
Driver's License Number & Issuer:	Driver's License Expiration Date:
Date of Birth:	Sex: ◯ Male ◯ Female
Previous Home Address:	Previous Business Address:

List the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. This includes relatives.

Name	Address

List the names of **any other disclosing** entity in which person with an ownership or control interest in the disclosing entity also has an ownership or control interest of at least 5% or more (put N/A if not applicable).

NOTE: Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of

Name	Address	Tax ID	%

Are you related as spouse, parent, child, or sibling to any other owner, officer, agent, managing employee, director or shareholder? ◯ Yes ◯ No If yes, please give names and relationships (Attach additional sheets if necessary):

Name	Relationship

X Initial Enrollment

ATN # NA – **Alabama Department of Mental Health Application**

PROVIDER DISCLOSURE FORM (cont.)

List any business transactions with wholly owned suppliers or any subcontractors totaling more than $25,000, during the last 12 months.

FULL LEGAL NAME	ADDRESS	AMOUNT OF BUSINESS TRANSACTION	RELATIONSHIP

Have you ever been excluded, debarred, or sanctioned from any state or federal program? ◯ Yes ◯ No

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____

_____

_____

Is your license currently suspended or restricted? ◯ Yes ◯ No

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____

_____

_____

Have you ever been convicted of a crime? (excluding minor traffic citations) ◯ Yes ◯ No

Convicted means that:

I. A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
   a) There is a post-trial motion or appeal pending, or
   b) The judgement of conviction or other record related to the criminal conduct has been expunged or otherwise removed;

II. A Federal, State or local court has made a finding of guilt against an individual or entity;

III. A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or

IV. An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgement of conviction has been withheld.

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license:

_____

_____

_____

_____

Do you have any outstanding criminal fines, restitution orders, or overpayments identified in this state or any other state? ◯ Yes ◯ No

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▸ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▸ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▸

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ▸	**Date** ▸

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Provider Contact / Location Information

Performing Provider NPI	Click or tap here to enter text.

Physical Location Address

Name	Click or tap here to enter text.
Address Street	Click or tap here to enter text.
Address City, State, ZIP (plus 4)	Click or tap here to enter text.
Business Phone	Click or tap here to enter text.
FAX Number	Click or tap here to enter text.
Contact Person	Click or tap here to enter text.
Contact Email	Click or tap here to enter text.
County	Click or tap here to enter text.

Mailing Address if Different

Street/PO Box	Click or tap here to enter text.
City	Click or tap here to enter text.
County	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip (plus 4)	Click or tap here to enter text.

Other Information

Region	Click or tap here to enter text.
Contract Type (IDW, LAH,	Click or tap here to enter text.
Federal Employer ID #	Click or tap here to enter text.
Vendor Customer Number	
Effective Date Requested	

IMMIGRATION STATUS ATTESTATION

Company Name: _____

I hereby attest that all workers on this project are either citizens of the United States of America or are in a proper and legal immigration status that authorizes them to be employed for pay within the United States.

_____
Signature of Business Representative

_____
Witness

_____
Date

REVOLVING DOOR ATTESTATION

Company Name: _____

I _____(vendor/contractor representative) attest that neither the vendor/contractor nor any of the vendor's/contractor's trustees, officers, directors, agents, servants or employees are a current employee of the Alabama Department of Mental Health (ADMH) and none of the same individuals have been employees of ADMH in violation of the revolving door prohibitions contained in the State of Alabama ethics laws. If any person involved in any way with the business relationship between vendor/contractor and the ADMH was employed with ADMH within the two years prior to the date of this application/contract, vendor/contractor has attached an opinion of the Alabama Ethics Commission indicating that the activity to be engaged in is not in violation of the Ethics Law.

_____
Signature of Business Representative

_____
Witness

_____
Date

ASSURANCE OF REGISTRATION WITH ALABAMA DEPARTMENT OF REVENUE

Company Name: _____

I Click or tap here to enter text._____ (vendor/contractor representative) certify that

_____ (company name) is not barred from entering into a contract due to failure to adhere to Alabama law by registering with the Alabama Department of Revenue. I agree that this application and/or any subsequent contract with the Alabama Department of Mental Health may be declared void if such certification is shown to be false.

_____
Signature of Business Representative

_____
Witness

_____
Date

CERTIFICATE OF COMPLIANCE WITH DRUG-FREE WORKPLACE REQUIREMENTS

Company Name: Click or tap here to enter text._____

I Click or tap here to enter text._____
(*President, Chairman of Board, or comparable authorized company official*)

agree that Click or tap here to enter text._____
(*company name*) will not engage in the unlawful manufacture, distribution, possession, or use of a controlled substance in conducting any activity associated with provision of products/services funded through ADMH-DDD HCBS waivers.

I further agree that if any company representatives are convicted of a criminal drug offense resulting from a violation occurring during the conduct of provision of products/services funded through ADMH-DDD HCBS waivers, I will immediately report said conviction(s) to the ADMH-DDD Associate Commissioner.

_____
Signature of Company President, Chairman of Board, or comparable authorized company official

_____
Witness

Date _____

CERTIFICATE OF COMPLIANCE WITH DRUG-FREE WORKPLACE PRACTICES

Click or tap here to enter text._____ (company name, hereinafter called "Applicant"), hereby agrees that it will continue to provide a drug-free workplace by: Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the applicant's workplace and specifying the actions that will be taken against employees for violation of such prohibition. Applicant further agrees that they have established an ongoing drug-free awareness program that informs employees about the dangers of drug abuse in the workplace; about maintaining a drug-free workplace; about available drug counseling, rehabilitation, and employee assistance programs; and about the penalties that may be imposed upon employees for drug abuse violations in the workplace.

Applicant agrees to make it a requirement that each employee to be engaged in the performance of provision of products/services funded through ADMH-DDD HCBS waivers be given a copy of the statement requiring that, as a condition of employment, the employee will:

1) Abide by the terms of the statement, and
2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction.

Applicant agrees to notify the ADMH-DDD Associate Commissioner, in writing, within ten (10) calendar days after receiving notice from an employee or otherwise receiving actual notice of such conviction.

Applicant agrees to take one of the following actions, within thirty (30) calendar days of receiving notice with respect to any employee who is so convicted:

1) Taking appropriate personnel action against such an employee, up to an including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency.

Applicant agrees to make a good faith effort to continue to maintain a drug-free workplace.

ALABAMA DEPARTMENT OF MENTAL HEALTH
DIVISION OF DEVELOPMENTAL DISABILITIES
WAIVER SERVICE PROVIDER/VENDOR APPLICATION

ASSURANCE OF COMPLIANCE WITH ALL FEDERAL STATUTES RELATING TO NONDISCRIMINATION

Company Name: _____

(company name, hereinafter called "Applicant"), hereby agrees that it will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L, 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title XI of the Education Amendments of 1972, as amended (20 U.S.C. 1681-1683 and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. 6101-6107), which prohibits discrimination on the basis of age. No person in the United States shall, on the ground of race, color, sex, disability, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this Assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose involving the provision of similar services or benefits. If any personal property is so provided, the assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this Assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance, and that the United States shall have the right to seek judicial enforcement of this Assurance. This Assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the Applicant.

_____

Signature of Company President, Chairman of Board, or comparable authorized company official

_____ Date: _____

Witness

ALABAMA DEPARTMENT OF MENTAL HEALTH
DIVISION OF DEVELOPMENTAL DISABILITIES
WAIVER SERVICE PROVIDER/VENDOR APPLICATION ID/LAH

SECTION 5A: COUNTIES COVERED BY PROGRAM

Select the counties and program(s) the applicant has the capacity to serve:(If ***All*** counties choose that option)

Region 1			Region 2				Region 3			Region 4			Region 5		
County	ID	LAH	County	C	ID	LAH	County	ID	LAH	County	ID	LAH	County	ID	LAH
Cherokee	☐	☐	**Bibb**		☐	☐	**Baldwin**	☐	☐	**Autauga**	☐	☐	**Blount**	☐	☐
Colbert	☐	☐	**Choctaw**		☐	☐	**Clarke**	☐	☐	**Barbour**	☐	☐	**Calhoun**	☐	☐
Cullman	☐	☐	**Fayette**		☐	☐	**Conecuh**	☐	☐	**Bullock**	☐	☐	**Chilton**	☐	☐
DeKalb	☐	☐	**Greene**		☐	☐	**Dallas**	☐	☐	**Butler**	☐	☐	**Clay**	☐	☐
Etowah	☐	☐	**Hale**		☐	☐	**Escambia**	☐	☐	**Chambers**	☐	☐	**Cleburne**	☐	☐
Franklin	☐	☐	**Lamar**		☐	☐	**Perry**	☐	☐	**Coffee**	☐	☐	**Coosa**	☐	☐
Jackson	☐	☐	**Marengo**		☐	☐	**Mobile**	☐	☐	**Covington**	☐	☐	**Jefferson**	☐	☐
Lauderdale	☐	☐	**Marion**		☐	☐	**Monroe**	☐	☐	**Crenshaw**	☐	☐	**Randolph**	☐	☐
Lawrence	☐	☐	**Pickens**		☐	☐	**Washington**	☐	☐	**Dale**	☐	☐	**Shelby**	☐	☐
Limestone	☐	☐	**Sumter**		☐	☐	**Wilcox**	☐	☐	**Elmore**	☐	☐	**St. Clair**	☐	☐
Madison	☐	☐	**Tuscaloosa**		☐	☐		☐	☐	**Geneva**	☐	☐	**Talladega**	☐	☐
Marshall	☐	☐	**Walker**		☐	☐		☐	☐	**Henry**	☐	☐		☐	☐
Morgan	☐	☐	**Winston**		☐	☐		☐	☐	**Houston**	☐	☐		☐	☐
	☐	☐			☐	☐		☐	☐	**Lee**	☐	☐		☐	☐
	☐	☐			☐	☐		☐	☐	**Lowndes**	☐	☐		☐	☐
	☐	☐			☐	☐		☐	☐	**Macon**	☐	☐		☐	☐
	☐	☐			☐	☐		☐	☐	**Montgomery**	☐	☐		☐	☐
	☐	☐			☐	☐		☐	☐	**Pike**	☐	☐		☐	☐
	☐	☐			☐	☐		☐	☐	**Russell**	☐	☐		☐	☐
	☐	☐			☐	☐		☐	☐	**Tallapoosa**	☐	☐		☐	☐
All Alabama Counties	☐	☐			☐	☐		☐	☐		☐	☐		☐	☐
	☐	☐			☐	☐		☐	☐		☐	☐		☐	☐

Company Name:

ALABAMA DEPARTMENT OF MENTAL HEALTH
DIVISION OF DEVELOPMENTAL DISABILITIES
WAIVER SERVICE PROVIDER/VENDOR APPLICATION

SECTION 5B: COUNTIES COVERED BY COMMUNITY WAIVER PROGRAM (CWP)

Select the counties and program(s) the applicant has the capacity to serve:(If ***All*** counties choose that option)

Region 1		Region 2		Region 3		Region 4		Region 5	
County	CWP	County	CWP	County	CWP	County	CWP	County	CWP
Decatur	☐	**Tuscaloosa**	☐	**Baldwin**	☐	**Elmore**	☐	**Jefferson**	☐
Limestone	☐	**Walker**	☐	**Mobile**	☐	**Houston**	☐	**XXXXXXXXXX**	☐
Madison	☐	**XXXXXXXXXXXX**	☐	**XXXXXXXXXX**	☐	**Montgomery**	☐	**All CWP Counties**	☐

Company Name: Click or tap here to enter text.

ADDITIONAL DOCUMENTS NEEDED FOR A COMPLETE APPLICATION

☐**COPY OF ALABAMA BUSINESS LICENSE (if applicable)**

☐**REGISTRATION WITH THE ALABAMA SECRETARY OF STATE**

☐**PROOF OF LIABILITY INSURANCE**

☐**CERTIFICATIONS (if applicable)**

☐**BACKGROUND SCREENING - Fee: $42.00** ***(ADMH will provide link via email once application is received)***

☐**NATIONAL PROVIDER IDENTIFER ENUMERATOR** **https://nppes.cms.hhs.gov/#/**

☐**ENROLLMENT IN STATE OF ALABAMA ACCOUNTING AND RESOURCE SYSTEM (STAARS)**

https://vendors.alabama.gov/

Company Name: Click or tap here to enter text.

***Qualifications for Positive Behavioral Supports Services ID/LAH Waivers

Level 1 Provider	Level 2 Provider	Level 3 Provider
Either a Ph.D. or MA Certified as a Behavior Analyst by the Behavior Analysis Certification Board	Either a Ph.D. or MA in the area of Behavior Analysis, Special Education or related field and 3 years' experience working with persons with Developmental Disabilities. Level 2 providers with a doctorate do not require supervision	Either a Qualified Developmental Disabilities Professional (QDDP) as required in 43 CFR 483.430 or be a Certified Assistant Behavior Analyst (BCaBA) Level 3 Providers must be supervised by either a Level 1 or Level 2 doctorate provider

***Qualifications for Positive Behavioral Supports CWP

- Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
- Worked in the Intellectual/Developmental Disability (IDD) field for five (5) years or more, two of which much have been at a professional level in a position that addressed challenging behavior or who worked in a related field (e.g., mental health).
- Holds an appropriate BA/BS level degree, master's degree, other advanced degree above the level of master's or equivalent experience in a field related to human services, such as psychology, social work, behavioral, disabilities, or rehabilitation psychology; Has completed training in positive behavior supports and/or behavioral psychology and/or applied behavioral science.