ALABAMA DEPARTMENT OF MENTAL HEALTH
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

CERTIFICATION APPLICATION AND SUPPORTING DOCUMENTATION

SERVICES TO BE PROVIDED TO TARGETED POPULATION

Use the letters and numbers below to complete the chart below. For example, if you propose to have Residential Services for men and women, put C in the Gender Served column, 1, 2, or 3 in the Age Group column, and the total number of people in the Number to be Served column.

Gender Served	**Age Group**
A = Male	1 = Children (4-12)
B = Female	2 = Adolescents (13-20)
C = Both	3= Adults (21+)

Services to be Provided	Gender Served	Age Group Served	Number to be Served
Supported Employment Services			
Hourly Services-Personal Care or Respite			
Day Habilitation			
Other (specify)			

BACKGROUND INFORMATION

1. Have you, your corporation or any other businesses owned/operated by you, or the business entity that is the subject of this application ever been the subject of any investigation for fraud or false claims related to Medicaid or any other state or federal program, or have you, your corporation, or any other businesses owned/operated by you, or the business entity you now represent ever been found in either an administrative or judicial proceeding to be guilty of fraud or false claims in conjunction with Medicaid or any other state or federal program?

   _____Yes _____No

   If yes, please provide a complete explanation (attach separate page if necessary) of the allegations, proceedings if any, and disposition if any.

2. Have you, your corporation or any other businesses owned/operated by you, or the business entity that is the subject of the application, or any business entity in which you have an ownership or control interest* ever had an application for certification denied by the Alabama Department of Mental Health (ADMH) or by any other state or federal licensing/certification authority , or having been certified or licensed by any such authority, have you, your corporation of any other business owned/operated by you, or the business entity that is the subject of this application, ever had a license/certification revoked or been decertified by the Alabama DMH/MR or by any other state or federal licensing/ certification authority.

   _____Yes _____No

   If yes, please provide a complete explanation (attach separate page if necessary) of the circumstances surrounding the denial, revocation or decertification and the final disposition of the same.

* An individual is considered to have an ownership or control interest in a provider entity if he has direct or indirect ownership of 5 percent or more, or is a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity as defined in under 42 CFR section 1001.1001(a) (1).

DOCUMENTS TO BE INCLUDED WITH APPLICATION

1. ___Copy of college transcript and diploma for Executive Director/Owner/Operator
2. ___Resume for the Executive Director/Owner/Operator demonstrating five years of professional experience with service provision with the intellectual and/or developmental disabilities (ID/DD) population.
3. ___Articles of Incorporation/Articles of Organization.
4. ___Board Bylaws/ LLC Operating Agreement.
5. ___Board/Executive Committee minutes for the past year.
6. ___Documentation/business bank statement indicating at least a 90-day cash reserve for operations.
7. ___Fiscal Policy (Organizational Fiscal Practices. Covers at least accounting guidelines, risk control, financial planning, financial reporting, revenue and expenditures, and asset management.)
8. ___Operational Budget.
9. ___Organizational Chart.
10. ___Description of primary geographic area to be served.
11. ___Copy of the program policies and procedures. (HCBS Policy, Basic Assurances, and Incident Prevention and Management System (IPMS) Manual)
12. ___Quality Improvement Plan.
13. ___Copy of individual rights policies and procedures.
14. ___Emergency Crisis Response Plan.
15. ___Written Description of each program for which certification is requested.
16. ___Resume, college transcript, college degree, professional license, of Clinical Director, Program Coordinators, Directors, Supervisors, RN/LPN, and/or Qualified Developmental Disabilities Professional (QDDP). QDDP training module certificate of completion.
17. ___Please provide a Statement of Disclosure for key staff (nurse and QDDP) that are employed at other ADMH contracted agencies. Include your understanding of each role and how you anticipate filling those roles.
18. ___Copy of staff training required prior to working with individuals receiving services.
19. ___Copy of staffing pattern/anticipated staff work schedule for services to be provided.
20. ___Prospective Provider Certificate of Attendance.
21. ___New Provider HCBS Compliance Agreement. (Initialed and signed in all designated areas.)

Untruthful/fraudulent information may be cause for denial of an application. No future applications will be considered.

If you are a currently certified entity submitting an application for a new sub-contractor, you must submit all items listed above.

If you are currently certified as a sub-contractor and wish to be an independently certified entity, you must submit all items listed above.

If you are a currently certified entity adding a program or service, please complete 12 through 15 only.