

Home and Community Based Waiver Services Provider Enrollment Information Form

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

ACT 150

Community HealthChoices

OBRA

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

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

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

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

Do you have a Home Health Agency license from the Dept. of Health and Medicare Certification?

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:

Requires Home Health Agency License

Home Health Aide

Home Health-Nursing (LPN)

Home Health-Nursing (RN)

Cognitive Rehabilitation Therapy

Teleservice Cognitive Rehabilitation Therapy

Behavior Therapy

Teleservice Behavior Therapy

Counseling Services

Teleservice Counseling Services

Nutritional Consultation

Teleservice Nutritional Consultation

Requires Home Health Agency or Outpatient or Community-Based Rehabilitation Agency

Home Health-Occupational Therapy

Home Health-Occupational Therapy - Assistant

Home Health-Physical Therapy

Home Health-Physical Therapy - Assistant

Home Health-Speech & Language Therapy

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
Community Integration

Employment Skills
Benefits Counseling
Teleservice Benefits Counseling

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, Contractor, or Equipment, Technology and Modifications Agency or Specialist*)

Community Transition Services (**OBRA Waiver ONLY**)

Home Adaptations (*Contractor's license if required by trade or Durable Medical Equipment provider*)

Home Delivered Meals (*Home Delivered Meals Vendors*)

Non-Medical, Non-Emergency Transportation (*Individual Driver, Licensed Transportation Agency, Public Transit Authority*)

Personal Emergency Response System (PERS) Installation **and** Maintenance (*Vendors of Personal Emergency Response Systems, Home Health Agency, Durable Medical Equipment and Supply Company*)

Vehicle Modifications (*Quality Assurance Program Accreditation by the National Mobility Equipment Dealers Assoc.*)

Specialized Medical Equipment and Supplies (*Durable Medical Equipment, Pharmacy, or Hearing Aid Dealer*)

Pest Eradication (*Pest Company license required*) (**CHC ONLY**)

Telecare Vendor Services (*please select one below*) (**CHC ONLY**)

Health Status Measuring and Monitoring (*Home Health Agency license from Dept. of Health*)

Activity & Sensor Monitoring (*Home Health Agency, Durable Medical Equipment and Supply Company, Pharmacy or Hospital license from the Dept. of Health*)

Medication Dispensing & Monitoring (*Home Health Agency, Durable Medical Equipment and Supply Company, Pharmacy or Hospital license from the Dept. of Health*)

Chore Services (*Registered as a vendor with the Commonwealth of Pennsylvania*) (**CHC ONLY**)

Vendor ID: _____

Has your agency been accredited by CARF as either a brain injury or community housing provider? 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

Residential Habilitation in a 4-8 group setting

Res. Habilitation Supplemental for 1:1

Res. Habilitation Supplemental for 2:1

(Must also be licensed as a Personal Care Home)

These services are available in the Community HealthChoices and OBRA waivers only

Supplemental Services cannot be selected without a corresponding group setting service

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

Documentation such as an organizational chart may be requested to verify that a provider has the capacity to provide services in the counties selected.

Region 1 All Region 1 Counties Allegheny Armstrong Beaver Fayette Greene Washington Westmoreland	Region 2 All Region 2 Counties Butler Cameron Clarion Clearfield Crawford Elk Erie Forest Jefferson Venango Lawrence McKean Mercer Potter Warren	Region 3 All Region 3 Counties Bedford Blair Cambria Indiana Somerset	Region 4 All Region 4 Counties Centre Clinton Columbia Lycoming Mifflin Montour Northumberland Snyder Tioga Union
Region 5 All Region 5 Counties Adams Cumberland Dauphin Franklin Fulton Huntingdon Juniata Lancaster Lebanon Perry York	Region 6 All Region 6 Counties Bradford Lackawanna Luzerne Monroe Pike Sullivan Susquehanna Wayne Wyoming	Region 7 All Region 7 Counties Berks Carbon Lehigh Northampton Schuylkill	Region 8 All Region 8 Counties Bucks Chester Delaware Montgomery Region 9 Philadelphia



STEP 4: Please answer all the following questions.

Will your agency provide any of the selected services in any of the following settings?

- Will your agency provide any of the selected services in any of the following settings?***

- Please describe the space where the service will be provided:***

[illegible]



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STEP 5: Choose an effective date for the services to begin and sign below. Services cannot be backdated.

Requested effective date: _____

Title

Signature of Authorized Representative

Date

Print Name

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.
<https://www.pa.gov/en/agencies/dhs/resources/medicaid/waivers.html>