



# COMMONWEALTH of VIRGINIA

## Department of Medical Assistance Services

### Developmental Disabilities Waivers

The Community Living Waiver  
The Family and Individual Supports Waiver  
The Building Independence Waiver  
Developmental Disabilities Case Management

### VIRGINIA MEDICAID PROVIDER ENROLLMENT PACKAGE

Thank you for your interest in becoming a participating provider with the Virginia Medicaid program. Upon receipt of your completed Virginia Medicaid / Family Access to Medical Insurance Security Plan (FAMIS) enrollment application and any required documents, your application will be processed. Processing of your application may take up to ten business days. Completed paper enrollment applications can be faxed or mailed to Virginia Medicaid Provider Enrollment Services at the following fax number or address.

Toll free Fax 1-888-335-8476

Virginia Medicaid Provider Enrollment Services  
PO Box 26803  
Richmond, VA 23261-6803

If you have any questions regarding your paper enrollment application, you can contact Provider Enrollment Services toll-free at 1-888-829-5373 or local 1-804-270-5105.

#### Contents:

- Enrollment Form Instructions - Read all instructions to ensure your enrollment application is complete and that all necessary documentation has been attached prior to submission.
- Enrollment Application - Make sure all required fields are complete prior to submission.
- Participation Agreement - This must be signed by the provider.

## ENROLLMENT FORM INSTRUCTIONS

### BEFORE YOU BEGIN THIS APPLICATION

- If your organization is applying to enroll for one of the three DD Waiver Services; Building Independence Waiver, Community Living Waiver, Family and Individual Supports Waiver or Developmental Disabilities Case Management and is not licensed through the Department of Behavioral Health and Developmental Services (DBHDS) you will need to complete the enrollment application that is required for your organization provider type and service. Applications can be found on the Virginia Medicaid Web portal [www.viriniamedicaid.dmas.virginia.gov](http://www.viriniamedicaid.dmas.virginia.gov) by selecting Provider Services, Provider Enrollment Forms and then select from the drop down menu provider type.
- If your organization is actively enrolled for service location and provider type for a DD Waiver service listed below, you can render those services under your active Atypical Provider Identification Number (API) or National Provider Identification (NPI) with Virginia Medicaid for the three DD Waiver Services or Developmental Disabilities Case Management Services. No new enrollment application is required.

Type of DD Waiver Service	Type of Enrollment Application to be completed
Assistive Technology	Durable Medical Equipment (DME) Supplier Enrollment Application  Note: A Community Services Board (CSB) can provide this service under current enrollment, no new enrollment is necessary.
Companion Services (Agency Directed)	Personal Care or Respite Care Enrollment Application
Consumer-Directed Service Facilitation	Consumer-Directed Support Coordination Enrollment Application
Electronic Home-Based Services (EHBS)	Durable Medical Equipment (DME) Supplier, Home Health Agency, Personal Care or Personal Emergency Response System (PERS) Enrollment Application.  Note: A CSB can provide this service under current enrollment, no new enrollment is necessary. A Center for Independent Living provider would complete DD Waiver Service enrollment application.
Environmental Modifications	Durable Medical Equipment (DME) Supplier Enrollment Application  Note: A Community Services Board (CSB) can provide this service under current enrollment, no new enrollment is necessary.
Individual and Family Caregiver Training	Individual and Family Caregiver Training Enrollment Application
Personal Assistance Services (Agency Directed)	Personal Care or Respite Care Enrollment Application
Personal Emergency Response System (PERS)	Home Health Provider, Personal Care, Durable Medical Equipment (DME), hospital, or PERS Manufacturer enrollment applications
Respite Services (Agency Directed)	Personal Care or Respite Care Enrollment Application

**SECTION I: PROVIDER DEMOGRAPHIC INFORMATION**

**1. Provider Identifier (API or NPI)**

**Atypical Provider Identifier (API)**

Leave this section blank if you have not obtained a National Provider Identifier (NPI) and are enrolling for one or more of the services listed below. These services have been identified as belonging to an Atypical Provider Category. A ten digit API will be assigned to your organization once application and services have been approved. This new ten digit API number will be used on all Medicaid business transactions (claims, Automated Response System telephone service (ARS), Virginia Medicaid web portal, etc.).

- Benefits Planning
- Community Coaching
- Community Engagement
- Community Guide
- Companion Services (Agency-Directed)
- Group Day Services
- Group Home Residential
- Group Supported Employment
- Independent Living Supports
- Individual Supported Employment
- In-home Supports
- Peer Mentor Supports
- Personal Assistance Services (Agency-Directed)
- Respite Services (Agency-Directed)
- Shared Living
- Sponsored Residential
- Supported Living Residential
- Transition Services
- Workplace Assistance

**National Provider Identifier (NPI) (Required for Below Services)**

If your organization is enrolling for the services listed below enter your organization's NPI. To participate as a provider of medical or health services for the Department of Medical Assistance Services (DMAS), you are required to obtain an NPI. DMAS has adopted the NPI as the standard for identifying all providers on all transactions, including paper claims. More information about the NPI and how to obtain one can be found at <http://www.cms.gov> under Regulations and Guidance, HIPAA Administrative Simplification, National Provider Identifier Standard (NPI).

- Assistive Technology
- Center-Based Crisis Supports
- Community Based Crisis Supports
- Crisis Support Services
- Developmental Disabilities Case Management - CSBs Only
- Electronic Home-Based Supports
- Environmental Modifications
- Personal Emergency Response System (PERS)
- Private Duty Nursing
- Skilled Nursing Services
- Therapeutic Consultation

**2. Individual Name (Required for an Individual) or Organization Name (Required for Organizations)**

Enter the individual name or organization which identifies you to the public. This name will be used on the Virginia Medicaid Provider Directory Search.

**3. Primary Servicing Address (Required)**

Enter your Primary Servicing Address in this section.

- A Post Office Box address is not acceptable as a service location.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.

**4. Correspondence Address (Required)**

Enter the address to which you would like correspondence (Medicaid Manual updates, Medicaid memos, etc.) sent.

- A Post Office Box is acceptable for this type of address.
- Indicate whether or not you want Medicaid correspondence sent through the United States Post Office to this address.
- Only one Correspondence Address is allowed per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.
- If the Correspondence Address is the same as the Primary Servicing Address, write SAME on the Attention line.

**5. Pay to Address (Optional)**

Enter the address to which you would like payments sent for services rendered.

- Only one Pay to Address is permitted per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.
- If the Pay to Address is the same as the Correspondence Address, write SAME on the Attention line.

**6. Remittance Advice Address (Optional)**

Enter the address to which you would like Remittance Advice sent for services rendered.

- Only one Remittance Advice Address is allowed per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.
- If the Remittance Address is the same as the Pay to Address, write SAME on the Attention line.

**7. Social Security Number (SSN) and Date of Birth (Required for individuals)**

Enter the Social Security Number (SSN) and Date of Birth of the individual provider if the provider is not personally incorporated under a Taxpayer Identification Number (TIN).

**8. IRS Name (Required)**

Enter the IRS name associated with the tax ID registered with the IRS.

**9. Taxpayer Identification Number (TIN) (Required for Organizations)**

Enter your nine-digit Taxpayer Identification Number (TIN). This may also be called your Employer Identification Number (EIN), Federal Employer Identification Number (FEIN), or Federal Tax Identification Number (FTIN).

**10. Doing Business as (DBA) Name (Optional)**

Enter the name under which the business or operation is conducted and presented to the community. This name will be used on the Virginia Medicaid Provider Search Directory.

**11. Requested Effective Date of Enrollment (Required)**

Enter the date that you are requesting your enrollment to begin.

- Effective date cannot be more than one year past the current date.
- Effective date will never be before the effective date of your license.

**12. Three DD Waivers Services, DD Case Management and Corresponding License Requirements (Required) (Required for Services Below)**

Select services you are applying to provide and choose a type of license and enter the license number, effective date and end date.

***Benefits Planning***

An eligible provider for this service shall be one of the following: A nationally certified Social Security Administration (SSA) Community Work Incentive Coordinators (CWIC); or A Department for Aging and Rehabilitative Services (DARS) certified Work Incentive Specialist Advocate (WISA) approved vendor.

Must have one of the following credentials:

- DARS written verification for certified Work Incentive Specialist Advocates (WISA).
- SSA certification provided by Community Work Incentives Coordinators (CWIC).

***Center-Based Crisis Supports***

Providers of this service who are licensed through DBHDS as one of the following:

- Group Home Service - REACH
- REACH Children's Residential Services

***Community-Based Crisis Supports***

Providers of this service who are licensed through DBHDS as the following:

- Outpatient Services/Crisis Stabilization - REACH

***Community Coaching***

Providers of this service who are licensed through DBHDS as the following:

- Non-centered based day support services

***Community Engagement***

Providers of this service who are licensed through DBHDS as the following:

- Non-centered based day support services

***Community Guide***

Provider of this service must have a signed provider participation agreement with DMAS. The provider designated in the Participation Agreement must directly provide the services and bill DMAS for reimbursement.

***Companion Services (Agency-Directed)***

Providers of this service who are licensed through DBHDS as one of the following:

- Group Home Residential Services
- Non-Center Based Day Support
- Respite Services License
- Supportive In-Home Residential Services

***Crisis Support Services***

Providers of this service must be licensed through DBHDS as one of the following:

- Non-residential Crisis Stabilization Services
- Residential Crisis Stabilization Service
- Outpatient Crisis Stabilization Service - REACH

***Developmental Disabilities Case Management –CSBs Only***

Only Community Services Board providers who are licensed through DBHDS for the following:

- Case Management Services

***Electronic Home-Based Services (EHBS)***

- Community Services Board/Behavioral Health Authority
- Center for Independent Living

***Group Day Services***

Providers of this service who are licensed by DBHDS as the following:

- Center-based and/or non-center based day support services

If you are a new provider, you must attach a copy of the HCBS Compliance letter from DBHDS before this application for enrollment can be approved.

***Group Home Residential***

Providers of this service who are licensed by DBHDS as the following:

- Group Home Residential

Or, provider who are licensed through Department of Social Services (DSS) as the following:

- DSS Approved as an Adult Foster Care Home

If you are a new provider, you must attach a copy of the HCBS Compliance letter from DBHDS before this application for enrollment can be approved.

***Group Supported Employment***

Providers of this service who hold an agreement through the Department of Agency and Rehabilitation Services (DARS) of Virginia as the following:

- DARS supported employment services vendor agreement

If you are a new provider, you must attach a copy of the HCBS Compliance letter from DBHDS before this application for enrollment can be approved.

***Independent Living Supports***

Providers of this service who are licensed by DBHDS as the following:

- Supportive In-Home Residential Services

***Individual Supported Employment***

Providers of this service who hold an agreement through the Department of Agency and Rehabilitation Services (DARS) of Virginia as the following:

- DARS Supported Employment Services Vendor Agreement

***In-Home Support***

Providers of this service who are licensed by DBHDS as the following:

- Supportive In-Home Residential Services

***Peer Mentor Supports***

The administering agency will be a DBHDS licensed provider of DD waiver services or Center for Independent Living.

Providers of this service must provide one of the following:

- Providers of this service who are licensed through DBHDS must provide a copy of their license and enter the begin date and end date of the license
- Providers of this service that are not licensed by the DBHDS must attach a copy of their Articles of Incorporation and provide the begin date and for the end date insert 09/30/9999 under the Center for Independent Living section

***Personal Assistance Services-Agency Directed***

Providers of this service who are licensed through DBHDS as one of the following:

- Group Home Residential Services
- Supportive In-Home Residential Services

***Private Duty Nursing***

Providers selecting this service are attesting that they meet all of the requirements set out in 12 VAC 30-122-110 through 12 VAC 30-122-140 and D.1.2.3.

Providers of this service who are licensed through DBHDS as one of the following:

- Day Support Services
- Residential Services
- Respite Services

***Respite Services (Select all that apply)***

Providers of this service who are licensed through DBHDS as one of the following:

- Center-Based Respite Services
- In-home Respite Services
- Out-of-home Respite Services
- Residential Services
- Supportive In-home Residential Services

Or, who are licensed through the Department of Social Services (DSS):

- Foster Care Home for Children
- Adult Foster Care Home (for individuals outside of that home)

***Shared Living***

Providers of this service who are licensed through DBHDS

***Skilled Nursing Services***

Providers selecting this service are attesting that they meet all of the requirements set out in 12 VAC 30-122-1320 and D.1.2.3.

Providers of this service who are licensed through DBHDS as one of the following:

- Day Support Services
- Residential Services
- Respite Services

***Sponsored Residential***

Providers of this service who are licensed by DBHDS as the following:

- Sponsored Residential Home Services License

If you are a new provider, you must attach a copy of the HCBS Compliance letter from DBHDS before this application for enrollment can be approved.

***Supported Living Residential***

Providers of this service who are licensed by DBHDS as the following:

- Supervised Living Residential Services License

If you are a new provider, you must attach a copy of the HCBS Compliance letter from DBHDS before this application for enrollment can be approved.

***Transition Services***

No license is required. Must complete and submit this application.

***Workplace Assistance Services***

Providers of this service who hold an agreement through DARS as the following:

- DARS Supported Employment services vendor agreement

Or, who are licensed through DBHDS as the following:

- Non-Center Based Day Support license

***Therapeutic Consultation Services***

Providers with Therapeutic Consultation Services would complete the following question.

**13. Therapeutic Consultation Services and Corresponding License (Required for Below Services)**

Select service for which you are licensed and applying to provide. Choose a type of license and enter the license number, effective date and end date.

***Behavioral Consultation – (Select all that apply)***

Providers of this service who are licensed through one of the following:

- Board Certified Behavioral Analyst (BCBA)
- Board Certified Associate Behavior Analyst (BCABA)

- License through Department of Health Professions (DHP) of Virginia as one of the following:
  - Licensed Clinical Social Worker
  - Licensed Professional Counselor
  - Psychiatrist
  - Psychiatric Clinical Nurse Specialist
  - Psychologist
- Positive Behavioral Supports Facilitator endorsed by the Partnership for People with Disabilities at Virginia Commonwealth University or other recognized PBS training organization.

***Physical Therapy Consultation***

Providers of this service who are licensed through DHP of Virginia as a Physical Therapist.

***Psychology Consultation***

Providers of this service who are licensed through the DHP of Virginia as one of the following:

- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Psychiatrist
- Psychiatric Clinical Nurse Specialist
- Psychologist

***Occupational Therapy Consultation***

Providers of this service who are licensed through DHP of Virginia as a Occupational Therapist.

***Therapeutic Recreation Consultation***

Providers of this service who are certified through the National Council for Therapeutic Recreation Certification (NCTRC) as a Therapeutic Recreational Specialist.

***Rehabilitation Consultation***

Providers of this service who are certified through the Virginia Department for Aging and Rehabilitative Services (DARS) Certification as one of the following:

- Certified Rehabilitation Specialist
- Rehabilitation Engineer

***Speech Therapy Consultation***

Providers of this service who are licensed through DHP of Virginia as a Speech Language Pathologist.

**14. Type of Applicant (Required)**

Indicate the Type of Applicant: Corporation, Limited Liability Company, Partnership, Individual or Government Entity.

- Corporation is defined as a legal entity or structure under the authority of the laws of a state consisting of a person or group of persons who become shareholders.
- Limited Liability Company is defined as a business structure allowed by state statute whose owners have limited personal liability for the debts and actions of the Limited Liability Company.
- Partnership is defined as the relationship existing between two or more persons who join and carry on a trade or business.
- Individual is defined as a single practitioner operating under his/her own SSN or TIN. Requires SSN and Date of Birth.
- Government Entity is defined as a "legally authorized or recognized agency, instrumentality, or other entity of Federal, State, or local government (including multijurisdictional agencies, instrumentalities, and entities)".

**15. Languages Other Than English Spoken at Practice (Optional)**

Select all that apply for languages that are spoken at your organization. If no language is selected, English only will be recorded.

**16. Signature Waiver (Required)**

Signature waiver allows for the submission of claim(s) which will contain the provider's computer generated, stamped, or typed signature instead of a hand written signature.

**SECTION II: DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION FOR DISCLOSING ENTITY, AUTHORIZED BY 42 C.F.R. §455.104 AND 42 C.F.R. §455.106**

This section must be completed by an authorized representative. An authorized representative is defined as an individual with designated authority to act on behalf of the individual, group of practitioners, or disclosing entity. If not a solo practitioner, then the authorized representative must be a partner, president, or secretary of the group of practitioners or disclosing entity.

**17. Ownership and Control Information for Disclosing Entity (Required)**

List any managing employee and/or any individual(s) or organization(s) who has any ownership or controlling interest in this provider entity or in any subcontractor. The term "managing employee" means any person with management oversight, (i.e. general manager, business manager, administrator, director, or other individual) who exercises operational or managerial control over the day-to-day operations or administrative oversight of the provider/business office, as an employee, under contract with or through any other contractual arrangement. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity.

Include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Type of ownership (Board of Directors, Controlling Interest, Managing Employee, Owner or Other)
- Address
- Percentage of ownership (Owners with 5% or greater ownership only)

If your organization is a non-profit or not-for-profit organization in accordance with IRS Section 501(c)(3):

- Enter 501(c)(3) under ownership
- Attach a list of your board of directors, including first name, last name or organization name, title (i.e. CEO, President), date of birth, SSN for individuals or Tax ID (TIN) for organizations, and address.

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

**18. Relationships (Required)**

List those individuals named in the previous question who are related to each other.

Include:

- Name from previous question
- Relationship, (spouse, parent, child, or sibling)
- Name of the person from previous question to whom they are related

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

**19. Subcontractors (Required)**

List any individuals with an ownership or controlling interest in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more.

Include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address
- Percentage of ownership

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.



**20. Other Disclosing Entity (Required)**

List the name, title, SSN/TIN, address and percentage of ownership of any other disclosing entity in which a person, with an ownership or controlling interest in this disclosing entity, has an ownership or control interest of at least 5% or more.

Include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address
- Percentage of ownership

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

**21. Criminal Offenses of Persons with Ownership or Controlling Interest (Required)**

List any individual or organization listed previously who has any ownership or controlling interest in the applicant that has been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct.

Criminal offenses that must be included are:

- Convictions for any health related crimes or misconduct
- Assessment of fines or penalties for any health related crimes or misconduct
- Exclusion from any Federal or State healthcare program due to:
  - o Fraud
  - o Obstruction of an investigation
  - o Controlled substance violation
  - o Any other crime or misconduct

Include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

Attach a copy of the final disposition.

**22. Criminal Offenses of Any Other Connected Individuals or Organizations (Required)**

If you check Yes, list any individual or contractor connected with your practice that has been convicted or assessed fines or penalties for any health related crimes or misconduct, or is excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct.

Criminal offenses that must be included are:

- Conviction for any health related crimes or misconduct
- Assessment of fines or penalties for any health related crimes or misconduct
- Exclusion from any Federal or State healthcare program due to:
  - o Fraud
  - o Obstruction of an investigation
  - o Controlled substance violation
  - o Any other crime or misconduct

Include:

- First and last name or organization name
- Date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

Attach a copy of the final disposition.

**23. Adverse Legal Actions (Required)**

Check Yes if the applicant has had any adverse legal actions imposed by:

- Medicare
- Medicaid
- Federal agency or program
- Any state's agency or program
- Any licensing or certification agency

If Yes, attach a copy of the final disposition.

**SECTION III: CLAIM PAYMENT AND PROCESSING INFORMATION**

All Virginia Medicaid providers that enroll must submit all claims electronically by Electronic Data Interchange (EDI) through a clearing house, or Direct Data Entry (DDE) through the Virginia Medicaid web portal ([www.viriniamedicaid.dmas.virginia.gov](http://www.viriniamedicaid.dmas.virginia.gov)). Providers must also enroll to receive their payments via Electronic Funds Transfer (EFT) for payment of those services. Any provider who cannot comply with these requirements for good cause must request an exemption describing why they cannot comply.

**24. Electronic Funds Transfer (Required)**

If you select "Yes" to participate in the Electronic Funds Transfer (EFT) of payments directly deposited into your account, you must provide:

- The account type that will receive your EFT deposits
- The name of the financial institution that will receive your EFT deposits
- The routing or ABA number of the financial institution above. Your banking institution's 9-digit routing number is sometimes called the ABA number. The routing number must begin with numbers that fall in the ranges 01-12, 1-32 or 61-72 (for example 079986597). Note the number on your deposit slip is not a valid routing number. Attach a voided check or ask your financial institution for a letter and attach a copy
- The account number is a code identifying the account that will be accepting your direct deposit

If you select "No", you must apply for an exemption and show good cause.

- Good cause may include, but is not limited to
  - o the unavailability of a banking institution capable of transacting business via EFT.
- To apply for an exemption, attach to this application either a letter from the financial institution or a letter from the applicant for consideration. The letter must:
  - o Be on letterhead, either a financial institution's or the applicant's
  - o Be signed
  - o Be dated
  - o Include the applicant's NPI
  - o Include a description of the good cause

**25. Electronic Claims Submission (Required)**

For more information on how to submit claims through Electronic Data Interchange (EDI) through a clearing house or through Direct Data Entry (DDE) for no cost on the Virginia Medicaid Web Portal, visit [www.viriniamedicaid.dmas.virginia.gov](http://www.viriniamedicaid.dmas.virginia.gov). This information is located in the Quick Links menu, Provider Services, EDI Support.

- Select "Yes" if you will submit claims using (EDI) through a clearing house or DDE through the Virginia Medicaid Web Portal, [www.viriniamedicaid.dmas.virginia.gov](http://www.viriniamedicaid.dmas.virginia.gov).
- If you select "No", you must apply for an exemption and show good cause.
  - o Good cause may include, but is not limited to:
    - Unavailability of necessary infrastructure in the geographic region
    - No mechanism to electronically submit for a particular claim type
    - Financial hardship
  - o To apply for an exemption, attach a letter to this application for consideration. The letter must:
    - Be on the applicant's letterhead
    - Be signed
    - Be dated
    - Include the applicant's NPI
    - Include a description of the good cause

**26. Electronic Remittance Advice (ERA) (Optional)**

Select "Yes" if you would like to request participation in electronic remittance advices as part of your enrollment with Virginia Medicaid and FAMIS and enter the Service Center Name and ID Number.

**27. Remarks (Optional)**

Enter any additional information you would like to be considered as part of your enrollment application.

# VIRGINIA MEDICAID ENROLLMENT FORM

## SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

### 1. Provider Identifier (API or NPI)

Atypical Provider Identifier (API) (Leave blank until assigned) \_\_\_\_\_

National Provider Identifier (NPI) (Required for some services) \_\_\_\_\_

### 2. Individual Provider Name (Required for Individuals) or Organization Name (Required for Organizations)

Enter the name which identifies you or your organization to the public.

First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_ Suffix \_\_\_\_\_ Title \_\_\_\_\_

Organization Name \_\_\_\_\_

### 3. Primary Servicing Address (Required)

Attention \_\_\_\_\_

Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone (Required) \_\_\_\_\_ Ext. \_\_\_\_\_ 24 Hour Phone \_\_\_\_\_

TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (Required) \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

### 4. Correspondence Address (Required)

Attention \_\_\_\_\_

Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone \_\_\_\_\_ Ext. \_\_\_\_\_

TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email (Required) \_\_\_\_\_

Do you to receive Medicaid correspondence sent through the post office at this address? ☐ Yes or ☐ No

### 5. Pay To Address (Optional)

Attention \_\_\_\_\_

Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone \_\_\_\_\_ Ext. \_\_\_\_\_

TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

### 6. Remittance Advice Address (Optional)

Attention \_\_\_\_\_

Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone \_\_\_\_\_ Ext. \_\_\_\_\_

TDD Phone \_\_\_\_\_ Fax Number \_\_\_\_\_ Email \_\_\_\_\_

### 7. Social Security Number (SSN) and Date of Birth (Required for Individuals)

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

### 8. IRS Name (Required)

\_\_\_\_\_

9. Taxpayer Identification Number (TIN) (Required for Organizations) \_\_\_\_\_

10. Doing Business as (DBA) Name (Optional) \_\_\_\_\_

11. Requested Effective Date Of Enrollment (Required) \_\_\_\_\_

12. **Developmental Disabilities (DD) Waiver Services, Developmental Disabilities Case Management and Corresponding License (Required)**

Choose the service(s) you wish to provide and enter the license or certification information for each. Attach a copy of your license if indicated. Acronyms are defined in the Instructions.

If you are a new provider, you must attach a copy of your compliance letter from DBHDS if you are requesting to be enrolled for any of the Home and Community Based Services (Group Home Residential, Sponsored Residential, Supported Living Residential, Group Day Services, Group Supported Employment) prior to this application being approved.

☐ **Benefits Planning**

DARS written verification for certified Work Incentive Specialist Advocates (WISA) : Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

SSA certification provided by Community Work Incentives Coordinators (CWIC): Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Center-Based Crisis Support**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Community-Based Crisis Supports**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Community Coaching**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Community Engagement**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Community Guide**

☐ **Companion Services (Agency-Directed)**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Crisis Supports Services**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Developmental Disabilities Case Management – CSBs Only**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Electronic Home Based Services**

DARS Vendor (CIL) #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Group Day Services**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Group Home Residential**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

DSS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Group Supported Employment**

DARS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Independent Living Supports**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Individual Supported Employment**

DARS Agreement #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **In-Home Supports**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Peer Mentor Supports**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Center for Independent Living: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Personal Assistance Services (Agency-Directed)**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Private Duty Nursing**

Providers selecting this service are attesting that they meet all of the requirements set out in 12 VAC 30-122-110 through 12 VAC 30-122-140 and D.1.2.3.

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Respite Services (Agency-Directed)**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

DSS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Shared Living**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Skilled Nursing Services**

Providers selecting this service are attesting that they meet all of the requirements set out in 12 VAC 30-122-1320 and D.1.2.3.

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Sponsored Residential**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Supported Living Residential**

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Transition Services**

☐ **Workplace Assistance Services**

DARS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

DBHDS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**13. Therapeutic Consultation Services and Corresponding License (Required for Below Services)**

Choose the service(s) you wish to provide and enter the license information for each. Attach a copy of your license if indicated. Acronyms are defined in the Instructions.

☐ **Behavioral Consultation – (Select all that apply)**

BCBA License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

BCABA License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

DHP License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

PBS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Occupation Therapy Consultation**

DHP License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Physical Therapy Consultation**

DHP License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Psychology Consultation**

DHP License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Recreation Therapy Consultation**

NCTRC License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Rehabilitation Consultation**

DARS License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

☐ **Speech Therapy Consultation**

DHP License #: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**14. Type of Applicant - Check Only One (Required)**

☐ Corporation ☐ Limited Liability Company

☐ Partnership ☐ Individual

☐ Government Entity

**15. Languages Other Than English Spoken at Practice - Check All That Apply (Optional)**

☐ Farsi ☐ Hindi ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Other: \_\_\_\_\_

**16. Signature Waiver ☐ Yes ☐ No (Required)**

I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.

**SECTION II: DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION FOR DISCLOSING ENTITY, AUTHORIZED BY 42 C.F.R. §455.104. AND 42 C.F.R. §455.106.**

**17. Ownership and Control Information for Disclosing Entity (Required)**

List any managing employee and/or any individual(s) or organization(s) that has any ownership or controlling interest in this provider entity. The term "managing employee" means any person with management oversight, (i.e. general manager, business manager, administrator, director, or other individual) who exercises operational or managerial control over the day-to-day operations or administrative oversight of the provider/business office, as an employee, under contract with or through any other contractual arrangement.

List the Individual Name or Organization Name, Title (i.e. CEO, MD, Pres.), Date of Birth, SSN/Tax ID (TIN), Type of Ownership, Address and Percentage of Ownership. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity.

---

Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Ownership Type	_____	Percent	_____
Street Address	_____	City	_____
State	_____	Zip	_____

---

Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Ownership Type	_____	Percent	_____
Street Address	_____	City	_____
State	_____	Zip	_____

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Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Ownership Type	_____	Percent	_____
Street Address	_____	City	_____
State	_____	Zip	_____

---

Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Ownership Type	_____	Percent	_____
Street Address	_____	City	_____
State	_____	Zip	_____

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If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

**18. Relationships (Required)**

List those individuals named in the previous question who are related to each other (spouse, parent, child, or sibling) and whom they are related to.

---

Name Listed Above	_____
Relationship (i.e. spouse, parent, child, or sibling)	_____
Is Related to (Name)	_____

---

Name Listed Above	_____
Relationship (i.e. spouse, parent, child, or sibling)	_____
Is Related to (Name)	_____

---

Name Listed Above	_____
Relationship (i.e. spouse, parent, child, or sibling)	_____
Is Related to (Name)	_____

---

Name Listed Above	_____
Relationship (i.e. spouse, parent, child, or sibling)	_____
Is Related to (Name)	_____

---

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).



**19. Subcontractors (Required)**

List the Name, Title, Date of Birth, SSN/TIN, Address and Percentage of Ownership for any individual with an ownership or controlling interest in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more.

---

Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Percent	_____	Street Address	_____
City	_____	State	_____
Zip	_____		_____

---

Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Percent	_____	Street Address	_____
City	_____	State	_____
Zip	_____		_____

---

Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Percent	_____	Street Address	_____
City	_____	State	_____
Zip	_____		_____

---

Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Percent	_____	Street Address	_____
City	_____	State	_____
Zip	_____		_____

---

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

**20. Other Disclosing Entity (Required)**

List the name, title, Date of Birth, SSN/TIN, Percent Ownership and Address of any other disclosing entity in which a person, with an ownership or controlling interest in this disclosing entity, has an ownership or control interest of at least 5% or more.

---

Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Percent	_____	Street Address	_____
City	_____	State	_____
Zip	_____		_____

---

Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Percent	_____	Street Address	_____
City	_____	State	_____
Zip	_____		_____

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Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Percent	_____	Street Address	_____
City	_____	State	_____
Zip	_____		_____

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Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Percent	_____	Street Address	_____
City	_____	State	_____
Zip	_____		_____

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If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

**21. Criminal Offenses of Persons with Ownership or Controlling Interest (Required)**

Has any individual or organization listed previously who has any ownership or controlling interest in the applicant that has been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?

☐ No ☐ Yes (if Yes please provide the Name, Title, Date of Birth, Address, and SSN/TIN information for individual(s) or organization(s). Attach copy of the final disposition.

Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Street Address	_____	City	_____
State	_____	Zip	_____

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Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Street Address	_____	City	_____
State	_____	Zip	_____

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Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Street Address	_____	City	_____
State	_____	Zip	_____

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Name/Organization	_____	Title	_____
Date of Birth	_____	SSN/TIN	_____
Street Address	_____	City	_____
State	_____	Zip	_____

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If more space is needed, attach additional paper listing all of the required information for the additional individual or organization.

**22. Criminal Offenses of Any Other Connected Individuals or Organizations (Required)**

Has any individual or contractor connected with your practice ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or is excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?

☐ No ☐ Yes (if yes, please provide the Name, Date of Birth, Address, and SSN/TIN information for the individual(s) or contractors below. Attach a copy of the final disposition.

Name/Organization	_____
Date of Birth	_____
SSN/TIN	_____
Street Address	_____
City	_____
State	_____
Zip	_____

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Name/Organization	_____
Date of Birth	_____
SSN/TIN	_____
Street Address	_____
City	_____
State	_____
Zip	_____

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Name/Organization	_____
Date of Birth	_____
SSN/TIN	_____
Street Address	_____
City	_____
State	_____
Zip	_____

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Name/Organization	_____
Date of Birth	_____
SSN/TIN	_____
Street Address	_____
City	_____
State	_____
Zip	_____

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If more space is needed attach additional paper listing all of the required information for the additional individual or organization.

**23. Adverse Legal Actions (Required)**

Indicate if the applicant has ever had any adverse legal actions imposed by Medicare, Medicaid, any other Federal or State agency or program, or any licensing or certification agency.

☐ No ☐ Yes If Yes, attach a copy of any final disposition documentation.

### SECTION III: CLAIM PAYMENT AND PROCESSING INFORMATION (Required)

#### 24. Electronic Funds Transfer (Required)

☐ Yes, I will participate in EFT of payments directly deposited into my financial account. Complete the following:

Account Type      ☐ Checking ☐ Savings ☐ Other

Name of Financial Institution \_\_\_\_\_

Routing or ABA number \_\_\_\_\_

Account Number \_\_\_\_\_

☐ No, I am filing for an exemption from participation in EFT for good cause.

☐ I am attaching a letter from my financial institution stating the inability of the institution to transact business using EFT.

☐ I am attaching a letter describing my good cause for exemption.

#### 25. Electronic Claims Submission (Required)

☐ I will submit claim(s) through Electronic Data Interchange (EDI) or Direct Data Entry (DDE) on the Virginia Medicaid Web Portal as part of my enrollment with Virginia Medicaid and FAMIS.

☐ I am requesting an exemption from filing my claim(s) electronically at this time for the following reasons:

☐ Unavailability of the infrastructure necessary to support electronic claims submission in my geographic region. If checked attach supporting documentation.

☐ No mechanism for electronic submission for the particular claim types I bill Virginia Medicaid. If checked attach supporting documentation.

☐ Financial Hardship. If checked, attach supporting documentation.

☐ Other: \_\_\_\_\_  
To be considered for an exemption, attach supporting documentation.

#### 26. Electronic Remittance Advice (ERA) (Optional)

☐ Yes, I would like to request participation in electronic remittance advices as part of my enrollment with Virginia Medicaid and FAMIS. Complete the following:

Service Center Name \_\_\_\_\_

Service Center ID Number \_\_\_\_\_

#### 27. Remarks (Optional)

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# COMMONWEALTH of VIRGINIA

## Department of Medical Assistance Services Medical Assistance Program

### Developmental Disabilities Waivers Participation Agreement

#### This is to certify:

Provider Name \_\_\_\_\_

NPI \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, and the legally designated State Agency for the administration of Medicaid.

1. The provider is authorized to practice under the laws of the state in which he is licensed and is not as a matter of state or federal law disqualified from participating in the Program.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.
6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
9. The provider agrees to comply with 42 CFR §455.105. Disclosure by providers: Information related to business transactions within 35 days of request.
10. Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party. This agreement may be terminated by DMAS if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department.
11. Except as otherwise provided by applicable state or federal law, all disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
12. The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.
13. This agreement shall commence upon the approval date of your enrollment application. Your effective date of participation is listed on your approval letter which is sent to your correspondence address upon approval of your application. The provider shall retain a copy of this approval letter as part of the Participation Agreement. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

**For Virginia Medicaid use only**

\_\_\_\_\_

Director, Division of Program Operations      Date

\_\_\_\_\_  
Original Signature of Provider

\_\_\_\_\_  
Date