Ohio | Department of Developmental Disabilities

APPLICATION FOR SUPPORTED LIVING/ HCBS WAIVER PROVIDER CERTIFICATION

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

☐ **I am applying for Independent Provider certification (i.e., I am a self-employed person who intends to provide services and shall not employ, either directly or through contract, anyone else to provide the services).**

OR

☑ **I am applying for Agency Provider certification (i.e., I am the Chief Executive Officer [CEO] of an entity that employs persons for the purpose of providing services). Check the statement below which describes your agency.**

- ☐ **I represent a small agency (i.e., one that serves or plans to serve 50 or fewer individuals).**

  OR

- ☐ **I represent a large agency (i.e., one that serves or plans to serve 51 or more individuals).**

☑ **I am applying for initial certification.**

OR

☐ **I am applying to add additional HCBS waiver service(s) to term of existing certification.**

OR

☐ **I am an existing agency with a new CEO (CEO must sign off on CERT-01 and must submit evidence that they meet the requirements under rule-see below). Existing Contract Number: _____**

☐ **I have been selected by a parent/guardian to serve an individual who is enrolled on a Medicaid Waiver**

Medicaid Billing Number of Individual you will serve: _____

Name of parent/guardian: _____ Phone # of parent/guardian: _____

NAME OF INDEPENDENT/AGENCY PROVIDER	L.A.M.B. INC.
NAME OF CEO OF AGENCY PROVIDER, IF APPLICABLE	Betty Boop
STREET ADDRESS	123 E. Circle St.
CITY/STATE/ZIP	Anywhere, OH 55555
COUNTY	Ross
SOCIAL SECURITY NUMBER OF INDEPENDENT PROVIDER OR TAX ID NUMBER OF AGENCY PROVIDER	12-3456789
AREA CODE & TELEPHONE NUMBER	740-555-1212
EMAIL ADDRESS	lambinc@hotmail.com

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

Counties in which services will be delivered.

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

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

FOR STATE USE ONLY

DODD Representative Signature	MBS Contract #	Effective Date	Date to ODJFS
ODJFS Representative Signature	**Medicaid Provider number**		**Date**

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

☑ Be at least 18 years of age

☑ Hold a high school diploma or GED (except for persons who held provider certification or were employed by a certified agency provider on September 30, 2009)

☑ Have a valid Social Security Number

☑ Have a State of Ohio identification, a valid driver's license, or other government-issued photo identification

☑ Have a current report from the Bureau of Criminal Identification and Investigation (BCII) which demonstrates he/she has not been convicted of or pleaded guilty to any of the offenses listed in division (E) of section 5126.28 of the Ohio Revised Code; a criminal record check by the Federal Bureau of Investigation is required for those who cannot present proof that they have been residents of Ohio for the five-year period prior to the date of the background investigation

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

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

BB ____ Meet the requirements of rule 5123:2-2-01 (*Provider Certification*) of the Ohio Administrative Code and other standards and assurances established under Chapter 5123. of the Ohio Revised Code and division 5123:2 of the Ohio Administrative Code for the specific service(s) to be provided

BB ____ Maintain a current mailing address on file with the Department

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

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

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

BB ____ Not be listed on the Abuser Registry established pursuant to sections 5123.50 to 5123.54 of the Ohio Revised Code

BB ____ Not be listed on the Nurse Aide Registry indicating that the Ohio Department of Health has made a determination of abuse, neglect, or misappropriation of property of a resident of a long-term care facility or residential care facility

BB ____ Be able to read, write, and understand English at a level sufficient to comply with all requirements set forth in administrative rules governing the services provided

BB ____ Be able to effectively communicate with the individual receiving services

BB ____ Provide services only to individuals whose needs he/she can meet

BB ____ Implement services in accordance with the ISP

BB ____ Take all reasonable steps necessary to prevent the occurrence or reoccurrence of incidents adversely affecting the health and safety of individuals served

BB ____ Comply with the requirements of behavior supports established under rules adopted by the department

BB ____ Ensure that anyone responsible for implementing behavior support plans receives training in the plan components prior to implementation of the plans

BB ____ Arrange for substitute coverage, if necessary, only from a provider certified by the department and as identified in the individual's ISP, notify the individual or legally responsible person(s) in the event that substitute coverage is necessary, and notify the person identified in the ISP when substitute coverage is not available

BB ____ Notify, in writing, the individual or the individual's guardian and the individual's service and support administrator in the event that the provider intends to cease providing services to the individual no less than 30 calendar days prior to termination of services

BB ____ Annually complete training in the provisions of rights of individuals set forth in sections 5123.62 to 5123.64 of the Ohio Revised Code and the requirements of rule 5123:2-17-02 (*Incidents Adversely Affecting Health and Safety*) of the Ohio Administrative Code

BB ____ Not provide services to his/her minor child (under age 18) or to his/her spouse

BB ____ Not engage in sexual conduct or have sexual contact with an individual for whom he/she is providing care

BB ____ Not administer any medication to or perform health care tasks for individuals who receive services unless he/she meets applicable requirements of Chapters 4723., 5123., and 5126. of the Ohio Revised Code and rules adopted under those chapters

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

☑ At least one year of full-time, paid work experience in the provision of services to individuals with developmental disabilities which included responsibility for personnel matters, supervision of employees, program services, and financial management

☑ A Bachelor's degree from an accredited institution or at least four years of full-time, paid work experience as a supervisor of programs or services for individuals with developmental disabilities

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

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

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

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

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

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

Application fees are non-refundable. If you are uncertain about which fee applies, contact the Provider Certification Unit at provider.certification@dodd.ohio.gov before submitting your application.

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

Betty Boop
Signature of independent provider/agency CEO applicant

6/1/10
Date

Return completed application with supporting documentation to:
Ohio Department of Developmental Disabilities
Accounts Receivable
30 East Broad Street, 13th Floor
Columbus, Ohio 43215
1-800-617-6733

Or email Provider.Certification@dodd.ohio.gov

Ohio Department of Mental Retardation and Developmental Disabilities

HCBS WAIVER TRANSMITTAL

NAME OF INDIVIDUAL APPLICANT			
NAME OF APPLICANT IF AGENCY	L.A.M.B. Inc.		
STREET ADDRESS, CITY AND ZIP CODE. (DO NOT USE PO BOX)	123 E. Circle St.		
	Anywhere	OHIO	55555
COUNTY	Ross		
EMAIL ADDRESS *(IF AVAILABLE)*	lambinc@hotmail.com		
SOCIAL SECURITY NUMBER OR TAX ID / EIN	12-3456789	DATE:	
TELEPHONE NUMBER	(AREA CODE FIRST) 740-555-1212		

	I have submitted a NOTARIZED application *(and all required supporting documentation)* for certification to deliver the following Individual Options (I/O) and Level One (L-1) Waiver service(s).	I am prepared to deliver services in the following counties:
	Adult Foster Care IO	
	Adaptive & Assistive Equipment IO	
	Adult Day Support or Vocational Habilitation IO & L1 Agency	
	Environmental Accessibility Adaptations L1	
	Environmental Modifications IO	
	Home Delivered Meals IO	
X	Homemaker/Personal Care IO & L1	Ross
	Interpreter IO	
	Nutrition IO	
	Respite IO & L1 Agency Only	
	Informal Respite L1 Individual Only	
	Personal Emergency Response Systems L1	
	Social Work IO	
	Specialized Medical Adapt/Assist Equipment & Supplies L1	
	Supported Employment Enclave and Community IO & L1	
X	Transportation L1	Ross
X	Transportation Mileage Other than to Access Adult Day Services IO	Ross
X	Non Medical Transportation Per Trip or Per Mile Rate IO & L1	Ross

FOR STATE USE ONLY

ODMRREPRESENTATIVE SIGNATURE	MBS CONTRACT #	EFFECTIVE DATE	DATE TO ODJFS
ODJFS REPRESENTATIVE SIGNATURE	**MEDICAID PROVIDER NUMBER**		**DATE**

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OR

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  OR

- ☐ **I represent a large agency (i.e., one that serves or plans to serve 51 or more individuals).**

☒ **I am applying for initial certification.**

OR

☐ **I am applying for renewal certification.**

OR

☐ **I am applying to add additional HCBS waiver service(s) to term of existing certification.**

☐ **I have been selected by a parent/guardian to serve an individual who is enrolled on a Medicaid Waiver**

Medicaid Billing Number of Individual you will serve: _____

Name of parent/guardian: _____ **Phone # of parent/guardian:** _____

NAME OF INDEPENDENT/AGENCY PROVIDER	L.A.M.B Inc
NAME OF CEO OF AGENCY PROVIDER, IF APPLICABLE	Betty Boop
STREET ADDRESS	123 E Circle St
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COUNTY	Ross
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☐	Home-Delivered Meals (IO waiver only)	
☒	Homemaker/Personal Care	ROSS
☐	Informal Respite (L1 waiver only)	
☐	Institutional Respite	
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☐	Social Work (IO waiver only)	
☐	Specialized Medical Equipment and Supplies (L1 waiver only)	
☐	Supported Employment-Community & Supported Employment-Enclave	
☒	Transportation (L1 waiver only)	ROSS
☒	Transportation Mileage other than to access adult day services (IO waiver only)	ROSS

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☒ Be at least 18 years of age

☒ Hold a high school diploma or GED (except for persons who held provider certification or were employed by a certified agency provider on September 30, 2009)

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BB Comply with the requirements of behavior supports established under rules adopted by the department

BB Ensure that anyone responsible for implementing behavior support plans receives training in the plan components prior to implementation of the plans

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☒ At least one year of full-time, paid work experience in the provision of services to individuals with developmental disabilities which included responsibility for personnel matters, supervision of employees, program services, and financial management

☒ A Bachelor's degree from an accredited institution or at least four years of full-time, paid work experience as a supervisor of programs or services for individuals with developmental disabilities

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☒ Incident reporting and investigation
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Application fees are non-refundable. If you are uncertain about which fee applies, contact the Provider Certification Unit at provider.certification@dmr.state.oh.us before submitting your application.

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

Betty Boop
Signature of independent provider/agency CEO applicant

3/31/2010
Date

Return completed application with supporting documentation to:
Ohio Department of Developmental Disabilities
Accounts Receivable
30 East Broad Street, 13th Floor
Columbus, Ohio 43215
1-877-289-3636

Or email Provider.Certification@dmr.state.oh.us

Submit completed signed application/agreement with required attachments to:
Provider Network Management Section
Provider Enrollment Unit
P.O. Box 1461
Columbus, OH 43216-1461
Call the Interactive Voice Response (IVR) System at 1-800-686-1516

(For State Use Only)

Ohio Department of Job and Family Services

OHIO HEALTH PLANS PROVIDER ENROLLMENT APPLICATION/TIME LIMITED AGREEMENT FOR ORGANIZATIONS

Complete all applicable items if you plan to bill Medicaid as a sole proprietor of a business, or if you are a publicly or privately held business with more than one owner. (This does not apply to individual practitioners or practitioner groups.)

Organizational Provider Types: - Required

Mark the ONE appropriate type

- ☐ Ambulance (82)
- ☐ Ambulatory Surgery Center (46)
- ☐ Ambulette (83)
- ☐ Assisted Living Waiver Provider (74)
- ☐ Durable Medical Equipment (76)
- ☐ End-Stage Renal Disease Dialysis Clinic (59)
- ☐ Family Planning Clinic (54)
- ☐ Federally Qualified Health Center (12)
- ☐ General Hospital (01)
- ☐ Hearing and Speech Clinic (58)
- ☐ Home Health Agency (Medicare Cert.) (60)
- ☐ Home Health Agency (JC/CHAPS) (16)
- ☐ Hospice (44)
- ☐ Independent Diagnostic Testing Facility (IDTF) (79)
- ☐ Independent Laboratory (80)
- ☐ Medicaid School Program (28)
- ☐ Mental Health Clinic (51)
- ☐ Mental Hospital (02)
- ☐ Optician (75)
- ☐ Outpatient Health Facility (04)
- ☐ Outpatient Rehabilitation Clinic (53)
- ☐ ODADAS Certified/Licensed Treatment Program
- ☐ PACE (08)
- ☐ Pharmacy (70)
- ☐ Portable X-ray Laboratory 81)
- ☐ Primary Care Clinic (50)
- ☐ Professional Dental School Clinic (56)
- ☐ Professional Optometry School Clinic (55)
- ☐ Public Health Department Clinic (52)
- ☐ Rural Health Clinic (05)
- ☐ Targeted Case Management (85)
- ☒ Waiver Service Provider (45)
- ☐ ODMH Certified Comm Mental Hlth Agency

Provider Identification: - Required

(Print or type entries)

Organization Name: L.A.M.B Inc

Abbreviated Organization Name *(If your name exceeds 30 spaces, indicate preferred abbreviation.)*:

Employer Identification Number: 12-3456789

You must attach a signed W-9 form

Address Information: - Required

Physical Location of Business *(Applicants: If more than one location, list Primary. Required field)*

Building Name / or / Department / or / In care of: L.A.M.B. Inc.

Business Address (Number, Street, Avenue, Route, etc. P.O. and Drop Boxes are not acceptable): 123 E. Circle St.

Suite Number:

City: Anywhere

County: Ross

State: OH

Zip Code (Zip +4, if possible): 55555

Telephone Number: 740-555-1212

"Pay to" Address *(Name & Address to which Payment and/or Remittance Advice is to be mailed)*

Building Name / or / Department / or / In care of:

Address:

Suite Number:

City:

State:

Zip Code (Zip + 4, if possible):

Mailing/Correspondence Address *(Name & Address to which all other material is to be mailed)*

Building Name / or / Department / or / In care of:

Address:

Suite Number:

City:

State:

Zip Code (Zip + 4, if possible):

(For State Use Only)

National Provider Identifier:

If you have received your National Provider Identifier (NPI) number, please report it here:

NPI number **

If you had a previous NPI number, please report it here:

NPI number

** You must attach a copy of the notice from the NPI Enumerator to verify the National Provider Identifier Number.

Medicare Identification Information: - Required if applicable

* You must attach copy of CLIA Certificate

PIN number*

PIN number*

OMERC number*

*You must attach copy of Department of Health and Human Services Approval Letter.

Clinical Laboratory Improvement Act Information - REQUIRED FOR ALL HOSPITALS AND ALL LABORATORIES

CLIA number*

CLIA number*

CLIA number*

* You must attach copy of CLIA Certificate

* You must attach copy of CLIA Certificate

Optional Categories of Service:

Check your Provider Type, and any other Categories of Service you are licensed and/or authorized to provide.

Provider Type	Optional Category of Service
☐ Ambulance (82)	☐ Ambulette Services (38)
☐ End-Stage Renal Disease Dialysis Clinic (59)	☐ Prescribed Drugs (30) ☐ Supplies & Med Equip (32)
☐ Family Planning Clinic (54)	☐ Supplies & Med Equip (32)
☐ General Hospital (01)	☐ Ambulance Services (37) ☐ Ambulette Services (38)
☐ Mental Health Clinic(51)	☐ Supplies & Medical Equip(32)

Provider Type	Optional Category of Service
☐ Outpatient Rehabilitation Clinic (53)	☐ Supplies & Med Equip (32)
☐ Primary Care Clinic (50)	☐ Dental Services (45) ☐ Optometric Services (47) ☐ Advanced Practice Nurse (21) ☐ Supplies and Medical Equip (32) ☐ Physician Services (43) ☐ EPSDT Services (40)
☐ Professional Optometry School Clinic (55)	☐ Supplies & Med Equip (32)
☐ Public Health Department Clinic (52)	☐ Dental Services (45) ☐ Optometric Services (47) ☐ Supplies & Medical Equip (32)

Federally Qualified Health Centers, Rural Health Facilities, Outpatient Health Facilities

Providers may be enrolled as only one type of alternative payment clinic. An "alternative payment clinic" shall be defined as an FQHC, rural health clinic (RHC), or outpatient health facility (OHF). Check the appropriate box:

☐ Section 330 of Public Health Service Act grants – recipient or under a contract with the recipient
(include documentation from CMS that identifies the specific service site(s) included in the 330 public health services project)

☐ Health and Human Services Certification as a Federally Qualified Health Center
(include documentation from US secretary of health and human services confirmation letter that the service site(s) is/are considered an FQHC look-alike with respect to Medicaid coverage)

(For State Use Only)

Medicaid School Program

Medicaid School Program

A Medicaid School Program Provider must document effort to coordinate with an eligible child's medical home. The documentation must indicate effort made to obtain a release of information that would allow notation of the eligible child's primary healthcare provider's contact information and/or Medicaid managed care plan in the child's special education record. The release must allow the Medicaid School Program Provider to share health informational records with a child's primary healthcare provider and/or Medicaid managed care plan. Documentation must also include the efforts made to establish protocol for a bilateral exchange of information with the primary healthcare provider or managed care plan consistent with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, as applicable. These efforts should facilitate the coordination and non-duplication of screening, diagnostic, and treatment services for the eligible child.

Ohio Department of Education Internal Retrieval Number (IRN): Internal Retrieval Number (IRN)*

Type of School District (*check one only*):

- ☐ City School
- ☐ Exempted Village
- ☐ Community School
- ☐ Local School
- ☐ State School for the Deaf
- ☐ State School for the Blind

Clinics *Check the applicable Clinic Provider Type , and attach a copy of the required documentation as indicated for your Provider Type*

Ambulatory Health Care Clinics – Required

Provider Type	Required documentation (to be submitted with application)
☐ 59 - End-Stage Renal Dialysis Clinic	☐ Medicare Certification as a Dialysis Clinic ☐ Licensure by the Ohio Department of Health as a dialysis provider
☐ 54 - Family Planning Clinic	☐ Affiliation with the Planned Parenthood Federation of America (PPFA) ☐ Grant award for the provision of family planning services under Title-X of the Public Health Services Act ☐ Grant award through the Ohio Department of Health for family planning services under the Child and Family Health Services program ☐ Grant award through the Ohio Department of Health's Women's Health Services, in accordance with rule 3701-68-01 of the Administrative Code
☐ 58 - Hearing and Speech Clinic	☐ Specialize in either speech language/audiology services or diagnostic imaging services
☐ 51 - Mental Health Clinic	☐ Ohio Department of Health Recognition as an Alcoholism Outpatient and After-care Services Program. ☐ Ohio Department of Mental Health Certification as an Outpatient Mental Health Facility.
☐ 53 – Outpatient Rehabilitation Clinic	☐ Medicare Certification as an Outpatient Rehabilitation Clinic OR ☐ Medicare Certification a Comprehensive Outpatient Rehabilitation Clinic
☐ 50 - Primary Care Clinic	☐ Joint Commission Accreditation ☐ Accreditation Association for Ambulatory Health Care (AAAHC) ☐ Healthcare Facilities Accreditation Program of the American Osteopathic Association ☐ Community Health Accreditation Program (CHAP) ☐ Receipt of state or federal grant funds for the provision of health services
☐ 56 – Professional Dental Dental Clinic	☐ Accreditation by the Council on Dental Education (CODA) of the American Dental Association (ADA)
☐ 55 – Professional Optometry School Clinic	☐ Accreditation by the Council on Optometry Education (ACOE) of the American Optometric Association
☐ 52 - Public Health Department Clinic	☐ Legal Status as a County Health Department, City Health Department, or Combined Health District

(For State Use Only)

Hospitals - Required

Hospital License Registry Number*

License Registry Date (mm/dd/yyyy)

Current License Registry Expiration Date* (mm/dd/yyyy)

*You must attach copy of License

Hospital Beds - You must attach a copy of the letter from Department of Health with Your Bed Certification.

TOTAL HOSPITAL BEDS _____

Please check all that apply and attach supporting documentation for each block checked

- ☐ Children's Hospital
- ☐ Hospital has a Distinct Part Psychiatric Unit
- ☐ Major Teaching Hospital
  (Submit intern to bed ratio from fiscal intermediary)
- ☐ Rural Referral Center
- ☐ For hospitals in Ohio, please specify Nursery Level
  (Submit documentation from Ohio Dept. of Health)
  - ☐ Level 1
  - ☐ Level 2
  - ☐ Level 3
- ☐ Rehabilitation Hospital
- ☐ Long Term Acute Care Hospital
- ☐ Cancer Hospital
- ☐ HMO owned Hospital
- ☐ Specialty Hospital
  (Please Specify)_____

If you provide Pharmacy and/or Ambulance/Ambulette services you must also complete the Pharmacy and Transportation sections of this application

National Provider Identifier: Secondary NPIs

Psychiatric Unit NPI

Rehabilitation Unit NPI

Hospital Cost Report Contact- Required

Name/Title		
Address		Suite Number
City	State	Zip Code (Zip + 4, if possible)
Phone Number	Fax Number	E-Mail Address

Hospital Care Assurance Program (HCAP) Contact

(If contact is not different from "Hospital Cost Report Contact,", leave blank.)

Name/Title		
Address		Suite Number
City	State	Zip Code (Zip + 4, if possible)
Phone Number	Fax Number	E-Mail Address

Upper Payment Limit (UPL) Program Contact

(If contact is not different from "Hospital Cost Report Contact,", leave blank.)

Name/Title		
Address		Suite Number
City	State	Zip Code (Zip + 4, if possible)
Phone Number	Fax Number	E-Mail Address

(For State Use Only)

Pharmacies - Required

State Pharmacy Board License Number*

DEA Registration Number*

*You must attach a copy of license.

*You must attach a copy of Controlled Substance Registration Certificate

Name of Licensed, Registered Pharmacist (in full and actual charge of the Pharmacy)(print or type.)

Pharmacist's License Number*

Pharmacist's Signature

Date of Signature (mm/dd/yyyy)

*You must attach a copy of license.

Medical Suppliers - Required

State Vendor's License Number*

*You must attach a copy of license.

or

Orthotics / Prosthetics License Number*

*You must attach a copy of license.

or

State Tax Exemption Certificate Number*

*You must attach a copy of Certificate.

Do you have a Respiratory Board license? ☐ YES ☐ NO (This is required to bill for respiratory services)

State Respiratory Board License Number*

*You must attach a copy of license.

Date license was issued (mm/dd/yyyy)

*You must attach a copy of license.

Date license expires (mm/dd/yyyy)

Are you dispensing hearing aids? ☐ YES ☐ NO If yes, please enter the appropriate License Number below.

Hearing Aid Dispensor License Number*

*You must attach a copy of license.

or

Audiologist License Number*

*You must attach a copy of license.

Independent Diagnostic Testing Facilities - Required

Physician's Certification: *I certify that* (check one):

- ☐ I own or partially own the facility and employ the operating personnel.
- ☐ I am a part-time employee or an employee under contract whose responsibilities include checking the procedural and quality control manuals, observing the operator's or technician's performance, verifying that the equipment and personnel meet applicable federal, state, and local licensure and registration requirements, and assuring that safe operating procedures and quality control procedures are used.

Physician's Name (print)

Physician's Signature

Date of Signature (mm/dd/yyyy)

Eligible Medicaid providers of Independent Diagnostic Testing Facility services must meet the following criteria:

1. Possess a current unrevoked or unsuspended Medicare Provider Number as an Independent Diagnostic Testing Facility.
2. Be in conformity with all applicable federal, state, and local laws and regulations.
3. Provide nonradiological services under the general supervision of a physician who is certified or meets the requirements and/or training in the performance and interpretation of diagnostic testing procedures.
4. Provide radiological services under the following conditions:
   a) The services are performed under the general supervision of a licensed doctor of medicine or licensed doctor of osteopathy who is qualified by advanced training and experience in the use of x-rays as defined below:
      i) The physician is certified in radiology by the American Board of Radiology or by the American Osteopathy Board of Radiology or possesses qualifications which are equivalent to those required for such certification;
      ii) The physician is certified or meets the requirements for certification in a specialty in which the physician has become qualified by experience and/or training in the use of x-rays for diagnostic purposes.
   b) All operators of the x-ray equipment must meet the following requirements:
      i) Successful completion of a program of formal training in x-ray technology of not less than 24 months duration in a school approved by the Council on Education of the American Medical Association, or have earned a bachelor of science degree or associate degree in radiology technology from an accredited college or university.
      ii) For those whose training was completed prior to July 1, 1966, but on or after July 1, 1960, successful completion of 24 full months of training under the direct supervision of a physician who meets the definition of a qualified physician.
5. Radiology procedures are conducted in compliance with radiology safety standards which assure that the equipment and the operating procedures used minimize the radiation exposure and hazards for patients, personnel, and other persons in the immediate environment. X-ray equipment and shielding are inspected by qualified individuals at intervals not greater than every 24 months.

(For State Use Only)

Ambulance/Ambulette Transportation Services

Are you publicly owned and operated? ☐ Yes ☐ No
If no, enter your *State Medical Transportation Board Service Number** here:

* You must attach a copy of the State Medical Transportation Board Certificate of Licensure

Medicare Certification Number (Ambulance Provider Applicants only)*

* You must attach a copy of the Medicare Certification

Ambulance/Ambulette Personnel

(This page may be copied as needed to list all drivers.)

Ambulance providers: All drivers must have EMT certification (include a copy of EMT card for each driver with the application)
A copy of each driver's driving record from the Bureau of Motor Vehicles to be submitted with the application.

Ambulette providers:
Each driver and each attendant must have a current card as proof of successful completion of the "American Red Cross" (or equivalent certifying organization) basic course in first aid and a CPR certification
Each card must be signed and a copy of each driver's card, front and back, must be included with the application
OR EMT certification for each driver/attendant (include a copy of each driver's/attendant's EMT card with the application)

List the driver/attendant information below. Be sure to include the appropriate certification cards with the application for each driver/attendant. Please print or type all responses.

Driver/Attendant's Name	EMT Card Number Required for Ambulance Drivers	American Red Cross Basic/ Community First Aid and CPR	EMT Expiration Date or Completed Date of American Red Cross Basic/ Community First Aid Training/CPR (mm/dd/yyyy)
Driver Attendant		First Aid: CPR:	EMT expiration date or First Aid completion date CPR completion date
Driver Attendant		First Aid: CPR:	EMT expiration date or First Aid completion date CPR completion date
Driver Attendant		First Aid: CPR:	EMT expiration date or First Aid completion date CPR completion date
Driver Attendant		First Aid: CPR:	EMT expiration date or First Aid completion date CPR completion date
Driver Attendant		First Aid: CPR:	EMT expiration date or First Aid completion date CPR completion date
Driver Attendant		First Aid: CPR:	EMT expiration date or First Aid completion date CPR completion date

(For State Use Only)

Requirements for Ambulette Vehicle Providers
Documents to be included with the application

You must include, with your application, copies of documents for each item listed on this page. In addition, all ambulette vehicle providers must have documented proof on file of compliance with the following requirements, to be available upon request from the Department of Job and Family Services.

Check each block to certify compliance and include required documentation

☐	Currently, the ambulette service is operating _____ vehicles. The provider maintains a valid current vehicle license registration with the Ohio Bureau of Motor Vehicles for each vehicle. Include a copy of the vehicle registration for each vehicle.
☐	Each vehicle displays the company logo, insignia, or name on both sides and rear of the vehicle. Include photos of each vehicle for verification.
☐	The provider maintains liability insurance coverage in the amount of not less than five hundred thousand dollars per occurrence and not less than five hundred thousand dollars in the aggregate, for any cause for which the provider would be liable. Include proof of insurance.
☐	The provider maintains bodily injury and property damage insurance with solvent and responsible insurers licensed to do business in this state for any loss or damage resulting from any occurrence arising out of or caused by the operation or use of any ambulette vehicle. The insurance plan shall insure each vehicle for the sum of not less than one hundred thousand dollars for bodily injury to or death of more than one person in any one accident and for the sum of fifty thousand dollars for damage to property arising from any one accident. Include proof of insurance.
☐	Each driver and attendant must submit himself or herself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been indicted, convicted, or pleaded guilty to violation cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the revised code shall not provide services to medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of rule 3701-13-06 of the Administrative Code apply. Include a copy of the BCI criminal background check results.
☐	Each driver and each attendant has current cards issued as proof of successful completion of the "American Red Cross" (or equivalent) basic or community course in first aid and CPR. Each card must be signed on the back by the driver or attendant who completed the course. Include a copy of each card for each driver and attendant with the application.
☐	Each driver must have a copy of his or her driving record provided from the Bureau of Motor Vehicles. The date of the driving record submitted at the time of the application must be no more than fourteen days prior to the date of application for employment. Persons with six or more points on their driving record in accordance with section 4507.02 of the Revised Code cannot be an ambulette driver. Include a copy of each driver's driving record with the application.
☐	The qualifications of each driver and each attendant must comply with local, state, and federal laws and regulations, including a valid driver's license and be eighteen years or older. Include a copy of a valid driver's license for each driver.

(For State Use Only)

Requirements for Ambulette Vehicle Providers

All ambulette providers must certify that they operate vehicles that meet the following standards and have documentation to verify compliance that is available upon request.

Check each block to certify compliance

☐	Each vehicle is specifically designed to transport one or more patients sitting in wheelchairs and has fasteners to secure the wheelchair to the floor or side of the vehicle to prevent wheelchair movement. In addition, the vehicle is equipped with restraints to secure the patient in the wheelchair.
☐	Each vehicle has a minimum ceiling to floor height of fifty-six inches.
☐	Each vehicle is equipped with a communication system capable of two-way communication.
☐	Each vehicle is equipped with a stable access ramp or hydraulic lift.
☐	The provider must conduct daily inspection and testing of the hydraulic lift or access ramp.
☐	Each vehicle is equipped with, at a minimum, a fire extinguisher and an emergency first-aid kit.
☐	Each vehicle has provisions for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and driver in the event of an accident.
☐	The provider must complete vehicle inspection documentation in the form of a checklist to include at a minimum wheelchair restraints, wheelchair lifts, lights, windshield wipers/washers, emergency equipment, mirrors, and brakes.
☐	The provider maintains on file evidence that at least an annual vehicle inspection was completed by the Ohio State Highway Patrol Safety Inspection Unit, or a certified mechanic and each vehicle has been determined to be in good working condition.
☐	Each ambulette driver and each attendant has an identification card available to the patient identifying his or her complete name and company affiliation.
☐	The provider maintains on file a signed statement from a licensed physician for each driver and attendant declaring that they do not have physical, including vision and hearing, or mental limitation likely to interfere with safe driving, passenger assistance, or emergency activity and does not have a communicable disease that could jeopardize the health or welfare of patients being transported.
☐	Each ambulette driver has undergone testing for alcohol and controlled substances in accordance with 49 CFR 382.
☐	Each ambulette and each attendant has completed a passenger assistance training course to include at a minimum the basic characteristics of major disabling conditions affecting ambulation, basic considerations for functional factors, management of wheelchairs, assistance and transfer techniques, environmental considerations, and emergency procedures.

(For State Use Only)

Disclosure and Ownership/Control Interest Statement

Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations in spaces provided. List any additional names and addresses on the proper section of the sheet provided.

1. A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organization, agency, or practice that have been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

☐ YES ☒ NO

Name	When? Give date (mm/dd/yyyy)	SSN/EIN
Name	When? Give date (mm/dd/yyyy)	SSN/EIN

1. B. Are there any directors, officers, agents, or managing employees of the institution, agency, organization, or practice who have ever been indicted or convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

☐ YES ☒ NO

Name	When? Give date (mm/dd/yyyy)	SSN/EIN
Name	When? Give date (mm/dd/yyyy)	SSN/EIN

2. A. List names, addresses, and SSNs for individuals, and the names, addresses, and Employer Identification Numbers (EIN) for organizations having direct or indirect ownership or a controlling interest in the entity or practice. Place an "X" in the box labeled Related for all names listed who are related to each other.

Name	Related	Address	SSN/EIN
Betty Boop	☐	123 E. Circle St, Anywhere OH 55555	12-3456789
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN

2. B. Type of Entity or Practice: ☐ Sole Proprietorship ☐ Partnership ☒ Corporation ☐ Unincorporated Associations
☐ Other (specify)_____

2. C. If the disclosing entity or practice is a corporation, list names, addresses, and SSNs of the Directors and the name, address, and EIN of the parent corporation, if applicable.

Name	Address	SSN/EIN
Betty Boop	123 E. Circle St, Anywhere OH 55555	12-3456789
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN

2. D. Have you ever been issued an Ohio Medicaid 7-digit Provider Number?

☐ YES ☒ NO If, YES, you must list them in the boxes below.

7-digit Provider Number	7-digit Provider Number	7-digit Provider Number	7-digit Provider Number

(For State Use Only)

2.E. Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership, or Members of the Board of Directors.) If yes, list names, addresses of individuals, and provider numbers. If under Title XIX, list vendor number.

☐ YES ☒ NO

Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number

3.A. Has there been a change in ownership or control within the last year? If yes, when? (mm/dd/yyyy)

☐ YES ☒ NO *ATTACH EXPLANATION*

B. Do you anticipate any change in ownership or control within the year? If yes, when? (mm/dd/yyyy)

☐ YES ☒ NO *ATTACH EXPLANATION*

4. Is this entity operated by a management company, or leased in whole or part by another organization? If yes, give date of change in operations.(mm/dd/yyyy)

☐ YES ☒ NO

5. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?

☐ YES ☒ NO

6. Is this entity chain affiliated? (If yes, list name, address of Corporation, and EIN number.)

☐ YES ☒ NO

Name	Address	EIN

7. Are there any Directors, Officers, Agents, or Managing Employees of the Institution, Agency, Organization, or Practice who have ever been indicted or convicted of a violation of State or Federal Law?

☐ YES ☒ NO

Name	Type of offense?	When, give date? (mm/dd/yyyy)	SSN/EIN

Hospitals, only:

8. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?

☐ YES ☐ NO If yes, give year of change. Current Beds Prior Beds

For State Use Only

Disclosure statement: Additional Names, Addresses, and Numbers by section.

Section: 1.A.

Who was it? Give name	When? Give date (*mm/dd/yyyy*)	SSN/EIN
Who was it? Give name	When? Give date (*mm/dd/yyyy*)	SSN/EIN
Who was it? Give name	When? Give date (*mm/dd/yyyy*)	SSN/EIN

Section: 1.B.

Who was it? Give name	When? Give date (*mm/dd/yyyy*)	SSN/EIN
Who was it? Give name	When? Give date (*mm/dd/yyyy*)	SSN/EIN
Who was it? Give name	When? Give date (*mm/dd/yyyy*)	SSN/EIN

Section: 2.A.

Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN

Section: 2.C.

Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN

(For State Use Only)

All providers must read the statements below, print name, initial, and date

In accordance with Executive Order 2007-01S, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2007-01S, (2) has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Executive Order 2007-01S is, in itself, grounds for termination of this contract or grand and may result in the loss of other contracts or grants with the State of Ohio.

A copy of Executive Order 2007-01S can be found at: http://www.dot.state.oh.us/dlc/governor.asp

Authorized Representative Name and Title *(please print)*	
Betty Boop	
Authorized Representative Initials	Date
BB	5-4-09

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary, as appropriate.

Authorized Representative Name and Title *(please print)*	
Betty Boop	
Authorized Representative Initials	Date
BB	5-4-09

For all Ambulatory Health Care Clinics Only

All Ambulatory Health Care Clinics must provide documentation indicating the facility:

* Is Free Standing -- no administrative, organizational, financial, or other connection with a hospital or long term care facility;
* Furnishes outpatient (non-institutional) health care by or under the direction of a physician or dentist;
* Has a fixed location or specifically designed mobile unit;
* Does not provide overnight accdommodations;
* Is not eligible as a Medicaid provider as a professional association of physicians, dentists, optometrists, opticians, podiatrists, or limited practitioners such as physical therapists, psychologists, or chiropractors endolled as a Medicare provider.

(For State Use Only)

OHIO MEDICAID PROVIDER AGREEMENT

(For all providers except Medicaid Managed Care Plans and Long-Term Care Facilities)

This provider agreement is a contract between the Ohio Department of Job and Family Services (the Department) and the undersigned provider of medical assistance services in which the Provider agrees to comply with the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies to.

1. Render medical assistance services as medically necessary for the patient and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department for no more than the usual and customary fee charged other patients for the same service.

2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Department. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in Chapter 5101:3 of the Administrative Code.

3. Accept the allowable reimbursement for all covered services as payment-in-full and, except as required in paragraph 2 above, will not seek reimbursement for that service from the patient, any member of the family, or any other person.

4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer.

5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Ohio Medicaid fraud control unit or their designees any information maintained under paragraph 4 above for audit or review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of Medicaid or Disability Assistance Medical payments and may result in termination from the Medicaid and Disability Assistance Medical programs.

6. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; specialty; additions, deletions, or replacements in group membership and hospital-based physicians; and address;

7. Disclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5101:3-1-17.3 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX services.

8. Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any independent contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title X beneficiaries.

9. To follow the regulations and policies set forth in the appropriate edition of the Medicaid Handbook.

10. Provide to ODJFS, through the court of jurisdiction, notice of any action brought by the provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to: "Office of Legal Services, Ohio Department of Job and Family Services, 30 East Broad Street - 31st Floor, Columbus, Ohio 43215".

11. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d).

This provider agreement may be canceled by either party upon 30 days written notice prior to termination date.

I further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive officer, or general partner of the business organization that is applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.

Certain provider agreements may be made retroactive (up to 12 months) to encompass dates on which the provider furnished covered services to a Medicaid consumer and the service has not been billed to Medicaid. If you meet this provision, please check this box. ☐
A failure to check this box shall be taken by ODJFS to mean that you waive your rights to a retroactive period of up to 12 months prior to the date ODJFS approves your application.

Authorized Representative Name and Title *(please print)*	
Betty Boop	
Authorized Representative Signature	Date
Betty Boop	5-4-09

Signature of Authorized Agent *(For State Use Only)*	Date

(For State Use Only)

For help completing the application, please call the Provider Enrollment Customer Service Line. You can reach the Provider enrollment Unit through the Interactive Voice Response Unit.

The telephone number is:

800-686-1516

Our business hours are 8:00 am to 4:30 pm Monday through Friday.

For State Use Only

Date Received(1)	Date Received(2)	Date Received(3)	Date Received(4)
Date Returned(1)	Date Returned(2)	Date Returned(3)	Date Returned(4)

Date Processed	Effective Date	Provider Number
Operator's Number		Ticket Number

VENDOR INFORMATION FORM

All applicable parts of the form must be completed by the vendor and returned to Ohio Shared Services signed.

SECTION 1 – PLEASE SPECIFY TYPE OF ACTION

- [X] NEW (W-9 OR W-8ECI FORM ATTACHED)
- [ ] ADDITIONAL ADDRESS (PROVIDE COPY OF INVOICE OR LETTER)
- [ ] CHANGE OF ADDRESS (PROVIDE ADDRESS TO BE REPLACED IN THE COMMENTS BOX ON NEXT PAGE)
- [ ] CHANGE OF TIN (NEW W-9 AND LETTER OF EXPLANATION OF CHANGE ATTACHED)
- [ ] CHANGE OF NAME (NEW W-9 AND LETTER OF EXPLANATION OF CHANGE ATTACHED)
- [ ] CHANGE OF PAYTERMS
- [ ] CHANGE OF CONTACT
- [ ] CHANGE OF PO DISPATCH METHOD

SECTION 2 – PLEASE PROVIDE VENDOR INFORMATION

LEGAL BUSINESS NAME: (MUST MATCH W-9 OR W-8ECI FORM)

L.A.M.B Inc

BUSINESS NAME, TRADE NAME, DOING BUSINESS AS: (IF DIFFERENT THAN ABOVE)

TAXPAYER ID # (TIN):

12-3456789

BUSINESS ENTITY: NOTE: IF SOLE PROPRIETOR, THE INDIVIDUAL'S NAME MUST APPEAR IN LEGAL BUSINESS NAME

- [X] CORPORATION
- [ ] PARTNERSHIP
- [ ] SOLE PROPRIETOR
- [ ] NON PROFIT
- [ ] INDIVIDUAL
- [ ] OTHER (PLEASE EXPLAIN):

INDUSTRY CLASSIFICATION:

- [ ] STANDARD INDUSTRIAL CLASSIFICATION (SIC) CODE
- [ ] NORTH AMERICAN INDUSTRY CLASSIFICATION SYSTEM (NAICS) CODE

SECTION 3 – PLEASE PROVIDE COMPLETE ADDRESS

ADDRESS: 123 E Circle St

COUNTY: Ross

CITY: Anywhere

STATE: OH

ZIP CODE: 55555

SECTION 4 – REMIT TO ADDRESS (IF DIFFERENT THAN ABOVE)

ADDRESS:

CITY: | STATE: | ZIP CODE:

SECTION 5 – CONTACT INFORMATION AND PERSON TO RECEIVE PURCHASE ORDER

NAME:

WEB SITE:

PHONE: | FAX: | E-MAIL:

SECTION 6 – IS YOUR BUSINESS CURRENTY CERTIFIED AS? (PLEASE CHECK)

☐ MBE (MINORITY BUSINESS ENTERPRISE) ☐ EDGE (ENCOURAGING DIVERSITY, GROWTH, & EQUITY) ☐ N/A

SECTION 7 – PAYMENT TERMS (PLEASE CHECK ONE. OTHERWISE NET 30 WILL BE APPLIED BY DEFAULT)

☐ 2/10 NET 30 ☒ NET 30 ☐ NET 45 ☐ NET 60 ☐ NET 90

SECTION 8 – PURCHASE ORDER DISTRIBUTION-OTHER THAN USPS MAIL (INPUT E-MAIL ADDRESS OR FAX # BELOW)

E-MAIL:

FAX:

SECTION 9 – PLEASE SIGN & DATE

SIGNATURE: Betty Boop | DATE: 3/31/2010

SECTION 10 – AGENCY CONTACT INFORMATION

AGENCY NAME: LAMB INC

PHONE NUMBER: (740) 555-1212 | E-MAIL: lambinc@hotmail.com

COMMENTS:

SUBMIT FORM TO:

Mail: Ohio Shared Services
4310 E. Fifth Ave. Columbus, OH 43219
Fax number: (614) 485-1039
E-mail: vendor@ohio.gov

QUESTIONS? PLEASE CONTACT:

Phone: 1 (877) OHIO - SS1 (1-877-644-6771)
1 (614) 338-4781
E-mail: vendor@ohio.gov

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)
Betty Boop

Business name, if different from above
L.A.M.B Inc.

Check appropriate box: ☐ Individual/Sole proprietor ☒ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ _____
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)
123 E. Circle St

Requester's name and address (optional)

City, state, and ZIP code
Anywhere, OH 55555

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 your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
___ : ___ : ____

or

Employer identification number
12 : 3456789

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).

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 on page 4.

Sign Here | Signature of U.S. person ▶ Betty Boop | Date ▶ 5-4-09

General Instructions

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

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

OHIO PUBLIC SAFETY
EDUCATION - SERVICE - PROTECTION

Ohio Department of Public Safety
DIVISION OF HOMELAND SECURITY
http://www.homelandsecurity.ohio.gov

GOVERNMENT BUSINESS AND FUNDING CONTRACTS

In accordance with section 2909.33 of the Ohio Revised Code

DECLARATION REGARDING MATERIAL ASSISTANCE/NO ASSISTANCE TO A TERRORIST ORGANIZATION

This form serves as a declaration of the provision of material assistance to a terrorist organization or organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List (see the Ohio Homeland Security Division Web site for reference copy of the Terrorist Exclusion List).

Any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided. Failure to disclose the provision of material assistance to such an organization or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree.

For the purposes of this declaration, "material support or resources" means currency, payment instruments, other financial securities, funds, transfer of funds, and financial services that are in excess of one hundred dollars, as well as communications, lodging, training, safe houses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives, personnel, transportation, and other physical assets, except medicine or religious materials.

COMPLETE THIS SECTION ONLY IF YOU ARE AN INDEPENDENT CONTRACTOR

LAST NAME	FIRST NAME	MI

HOME ADDRESS			
CITY	STATE	ZIP	COUNTY

HOME PHONE	WORK PHONE

COMPLETE THIS SECTION ONLY IF YOU ARE A COMPANY, BUSINESS OR ORGANIZATION

LAST NAME	FIRST NAME	MI
Boop	Betty	

BUSINESS/ORGANIZATION NAME	PHONE
L.A.M.B Inc.	740-555-1212

BUSINESS ADDRESS			
123 E. Circle St.			
CITY	STATE	ZIP	COUNTY
Anywhere	OH	55555	Ross

DECLARATION

In accordance with section 2909.32 (A)(2)(b) of the Ohio Revised Code

For each question, indicate either "yes," or "no" in the space provided. Responses must be truthful to the best of your knowledge.

1. Are you a member of an organization on the U.S. Department of State Terrorist Exclusion List? ☐ Yes ☒ No
2. Have you used any position of prominence you have with any country to persuade others to support an organization on the U.S. Department of State Terrorist Exclusion List? ☐ Yes ☒ No
3. Have you knowingly solicited funds or other things of value for an organization on the U.S. Department of State Terrorist Exclusion List? ☐ Yes ☒ No
4. Have you solicited any individual for membership in an organization on the U.S. Department of State Terrorist Exclusion List? ☐ Yes ☒ No
5. Have you committed an act that you know, or reasonably should have known, affords "material support or resources" to an organization on the U.S. Department of State Terrorist Exclusion List? ☐ Yes ☒ No
6. Have you hired or compensated a person you knew to be a member of an organization on the U.S. Department of State Terrorist Exclusion List, or a person you knew to be engaged in planning, assisting, or carrying out an act of terrorism? ☐ Yes ☒ No

In the event of a denial of a government contract or government funding due to a positive indication that material assistance has been provided to a terrorist organization, or an organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List, a review of the denial may be requested. The request must be sent to the Ohio Department of Public Safety's Division of Homeland Security. The request forms and instructions for filing can be found on the Ohio Homeland Security Division Web site.

CERTIFICATION

I hereby certify that the answers I have made to all of the questions on this declaration are true to the best of my knowledge. I understand that if this declaration is not completed in its entirety, it will not be processed and I will be automatically disqualified. I understand that I am responsible for the correctness of this declaration. I understand that failure to disclose the provision of material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List, or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree. I understand that any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided by myself or my organization. If I am signing this on behalf of a company, business or organization, I hereby acknowledge that I have the authority to make this certification on behalf of the company, business or organization referenced on page 1 of this declaration.

X Bettie Bishop — 5-4-09

APPLICANT SIGNATURE — DATE

Ohio | Department of Developmental Disabilities

PROVIDER CERTIFICATION APPLICATION ADDENDUM
HOMEMAKER/PERSONAL CARE

Please carefully review and complete this form and submit all appropriate documentation.

NAME OF INDEPENDENT/AGENCY PROVIDER	L. A. M. B. Inc
NAME OF CEO OF AGENCY PROVIDER, IF APPLICABLE	Betty Boop

DEFINITION OF HOMEMAKER/PERSONAL CARE

"Homemaker/Personal care" means the coordinated provision of a variety of services, supports and supervision necessary for the health and welfare of an individual which enables the individual to live in the community. These are tasks directed at increasing the independence of the individual within his/her home or community. The service includes tasks directed at the individual's immediate environment that are necessitated by his or her physical or mental condition (including emotional and/or behavioral) and is of a supportive or maintenance type. This service will help the individual meet daily living needs, and without this service, alone or in combination with other waiver services, the individual would require institutionalization.

The following standards apply to each independent provider and each employee, contractor, and employee of a contractor of an agency provider who is engaged in a direct services position. Independent providers must submit evidence of the following standards upon application. Please check the box to indicate that the documentation is included.

☐ Hold valid American Red Cross or equivalent certification in First Aid

☐ Hold valid American Red Cross or equivalent certification in CPR

☐ Have completed eight hours of training that addresses the following topics:

- Overview of serving individuals with developmental disabilities
- Rights of individuals set forth in sections 5123.62 to 5123.64 of the Ohio Revised Code
- Overview of basic principles and requirements for providing HCBS waiver services
- Requirements of rule 5123:2-17-02 (*Incidents Adversely Health and Safety*) of the Ohio Administrative Code
- Universal precautions for infection control, including hand washing and the disposal of bodily waste

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

Each applicant must initial the following to indicate your understanding and assurance to comply.

BB The provider acknowledges the provider's ongoing responsibility to coordinate with designated persons and family members, where appropriate, to ensure the provision of coordination of services.

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

Betty Boop
Signature of Independent Provider/Agency CEO Applicant

3/31/2010
Date

Return completed application with supporting documentation to:
Ohio Department of Developmental Disabilities
Office of Provider Certification
30 East Broad Street, 13th Floor
Columbus, Ohio 43215
1-877-289-3636
Or email Provider.Certification@dmr.state.oh.us

Ohio | Department of Developmental Disabilities

PROVIDER CERTIFICATION APPLICATION ADDENDUM
TRANSPORTATION

Please carefully review and complete this form and submit all appropriate documentation.

NAME OF INDEPENDENT/AGENCY PROVIDER	L.A.M.B Inc
NAME OF CEO OF AGENCY PROVIDER, IF APPLICABLE	Betty Boop

DEFINITION OF TRANSPORTATION

"Transportation" means a service offered in order to enable individuals served on the Level One waiver to gain access to waiver and other community services, activities, and resources specified by the plan of care. This service is offered in addition to medical transportation required under Title 42 of the Code of Federal Regulations, section 431.53 (October 1, 2001) and transportation services under the state plan as defined at Title 42 of the Code of Federal Regulations, section 440.170(a) (October 1, 2001), if applicable, and shall not replace them. Transportation services under the Level One waiver shall be offered in accordance with the individual's ISP. Whenever possible, family, neighbors, friends or community agencies which can provide this service without charge, will be utilized.

The following standards apply to each independent provider and each employee, contractor, and employee of a contractor of an agency provider who is engaged in a direct services position. Independent providers must submit evidence of the following standards upon application. Please check the box to indicate that the documentation is included.

☐ Hold valid American Red Cross or equivalent certification in First Aid

☐ Hold valid American Red Cross or equivalent certification in CPR

☐ Have completed eight hours of training that addresses the following topics:

- Overview of serving individuals with developmental disabilities
- Rights of individuals set forth in sections 5123.62 to 5123.64 of the Ohio Revised Code
- Overview of basic principles and requirements for providing HCBS waiver services
- Requirements of rule 5123:2-17-02 (*Incidents Adversely Affecting Health and Safety*) of the Ohio Administrative Code
- Universal precautions for infection control, including hand washing and the disposal of bodily waste

☐ Hold a valid driver's license as specified by Ohio law

☐ Have proof of insurance coverage as specified under Sections 4509.101 and 4509.47 of the Ohio Revised Code, as applicable

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

Each applicant must initial the following to indicate your understanding and assurance to comply.

BB The provider shall maintain documentation from the Department of the provider's certification.

Each applicant for independent provider certification must initial the following to indicate your understanding and assurance to comply.

_____ The provider shall immediately report in writing to the Department, if his/her driver's license is suspended or revoked.

Each applicant for agency provider certification must initial the following to indicate your understanding and assurance to comply.

BB The provider shall employ a chief executive officer who is responsible for personnel matters, supervision of employees, program services, and financial management.

BB The provider shall have written policies and procedures that address the applicant's management practices regarding its table of organization and a requirement that drivers providing transportation services must be at least 18 years of age.

BB The provider shall require all drivers to immediately report in writing to the agency provider, if their driver's license is suspended or revoked.

BB The provider shall not permit a driver whose license has been suspended or revoked to provide transportation services.

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

Betty Boop
Signature of Independent Provider/Agency CEO Applicant

3/31/2010
Date

Return completed application with supporting documentation to:
Ohio Department of Developmental Disabilities
Office of Provider Certification
30 East Broad Street, 13th Floor
Columbus, Ohio 43215
1-877-289-3636

Or email to Provider.Certification@dmr.state.oh.us

Ohio | Department of Developmental Disabilities

PROVIDER CERTIFICATION APPLICATION ADDENDUM
TRANSPORTATION MILEAGE OTHER THAN TO ACCESS ADULT DAY SERVICES

Please carefully review and complete this form and submit all appropriate documentation.

NAME OF INDEPENDENT/AGENCY PROVIDER	L. A. M. B INC
NAME OF CEO OF AGENCY PROVIDER, IF APPLICABLE	Betty Boop

DEFINITION OF NON-MEDICAL TRANSPORTATION TO ACCESS ADULT DAY SERVICES

"Transportation mileage" means a transportation service offered by a provider other than medical transportation available through Ohio's approved Medicaid state plan and non-medical transportation as defined in rule 5123:2-9-18 of the Ohio Administrative Code.

The following standards apply to each independent provider and each employee, contractor, and employee of a contractor of an agency provider who is engaged in a direct services position. Independent providers must submit evidence of the following standards upon application. Please check the box to indicate that the documentation is included.

☐ Hold valid American Red Cross or equivalent certification in First Aid

☐ Hold valid American Red Cross or equivalent certification in CPR

☐ Have completed eight hours of training that addresses the following topics:

- Overview of serving individuals with developmental disabilities
- Rights of individuals set forth in sections 5123.62 to 5123.64 of the Ohio Revised Code
- Overview of basic principles and requirements for providing HCBS waiver services
- Requirements of rule 5123:2-17-02 of the Ohio Administrative Code
- Universal precautions for infection control, including hand washing and the disposal of bodily waste

☐ Hold a valid driver's license as specified by Ohio law

☐ Have proof of insurance coverage

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

Each applicant for independent provider certification must initial the following to indicate your understanding and assurance to comply.

_____ The provider shall immediately report in writing to the Department, if his/her driver's license is suspended or revoked.

Each applicant for agency provider certification must initial the following to indicate your understanding and assurance to comply.

BB The provider shall require all drivers to immediately report in writing to the provider, if their driver's license is suspended or revoked.

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

Betty Boop
Signature of Independent Provider/Agency CEO Applicant

3/31/2010
Date

Return completed application with supporting documentation to:

Ohio Department of Developmental Disabilities
Office of Provider Certification
30 East Broad Street, 13th Floor
Columbus, Ohio 43215
1-877-289-3636
Or email Provider.Certification@dmr.state.oh.us

Ohio | Department of Developmental Disabilities

PROVIDER CERTIFICATION APPLICATION ADDENDUM
ADULT FOSTER CARE

Please carefully review and complete this form and submit all appropriate documentation.

NAME OF INDEPENDENT/AGENCY PROVIDER	L.A.M.B. Inc
NAME OF CEO OF AGENCY PROVIDER, IF APPLICABLE	Betty Boop

DEFINITION OF ADULT FOSTER CARE SERVICES

"Adult foster care" means personal care and supportive services (e.g., homemaker, chore, and medication oversight to the extent permitted under state law) provided in a private home by an unrelated, principal care giver who lives in the home and whose primary, legal residence is that home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. Adult foster care services, their associated activities, and skill development proximate the rhythm of life that naturally occurs as part of living in the family home. Homemaker and chore services are furnished to the individual as a component of adult foster care. Due to the environment provided by foster care, segregating these activities into discrete services is impractical.

The following standards apply to each independent provider and each employee, contractor, and employee of a contractor of an agency provider who is engaged in a direct services position. Independent providers must submit evidence of the following standards upon application. Please check the box to indicate that the documentation is included.

☐ Hold valid American Red Cross or equivalent certification in First Aid

☐ Hold valid American Red Cross or equivalent certification in CPR

☐ Have completed eight hours of training that addresses the following topics:
- Overview of serving individuals with developmental disabilities
- Rights of individuals set forth in sections 5123.62 to 5123.64 of the Ohio Revised Code
- Overview of basic principles and requirements for providing HCBS waiver services
- Requirements of rule 5123:2-17-02 of the Ohio Administrative Code
- Universal precautions for infection control, including hand washing and the disposal of bodily waste

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

Each independent/agency applicant must initial the following to indicate your understanding and assurance to comply.

BB The applicant meets the requirements for homemaker/personal care certification as outlined in rule 5123:2-13-04 (*Individual Options Waiver – Homemaker/Personal Care*) of the Ohio Administrative Code.

BB The total number of individuals (including participants served under the waiver) with developmental disabilities living in the home shall not exceed four.

BB Unless the home is licensed under section 5123.19 of the Ohio Revised Code, the adult foster care provider shall not provide adult foster care services under the waiver to more than three of the individuals living in the home.

BB Neither providers of adult foster care nor principal care givers of adult foster care shall be related by blood, adoption, or marriage to an individual receiving adult foster care services.

BB Neither providers of adult foster care nor principal care givers of adult foster care shall be the full guardian of an individual receiving adult foster care services.

BB Providers of adult foster care shall not bill adult foster care on the same day as homemaker/personal care.

BB Providers shall document services delivered in accordance with the adult foster care rule.

BB Providers shall identify adult foster care as a service in the individual's written ISP prior to service being delivered and in the PAWS submitted to the department.

Each applicant for independent provider certification must initial the following to indicate your understanding and assurance to comply.

____ Independent providers of adult foster care shall reside in the home where services are delivered and that home shall be their primary legal residence.

____ Independent providers of adult foster care shall not subcontract the provisions of adult foster care services.

Each applicant for agency provider certification must initial the following to indicate your understanding and assurance to comply.

BB Agency providers of adult foster care shall either reside in the home where services are delivered and that home shall be their primary legal residence or they shall employ or subcontract with a principal care giver who shall reside in the home where services are delivered and that home shall be the principal care giver's primary legal residence.

BB Agency providers of adult foster care may subcontract the provision of adult foster care services in accordance with paragraph (I) of rule 5123:2-13-04 (*Individual Options Waiver – Homemaker/Personal Care*) of the Ohio Administrative Code.

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

Betty Y Boop
Signature of Independent Provider/Agency CEO Applicant

3/31/2010
Date

Return completed application with supporting documentation to:
Ohio Department of Developmental Disabilities
Office of Provider Certification
30 East Broad Street, 13th Floor
Columbus, Ohio 43215
1-877-289-3636

Or email Provider.Certification@dmr.state.oh.us

Ohio | Department of Developmental Disabilities

PROVIDER CERTIFICATION APPLICATION ADDENDUM
NON-MEDICAL TRANSPORTATION TO ACCESS ADULT DAY SERVICES

Please check which service(s) you are seeking certification to provide.

☐ Per trip rate ☐ Per mile rate ☐ Both

Please carefully review and complete this form and submit all appropriate documentation.

NAME OF INDEPENDENT/AGENCY PROVIDER	L.A.M.B INC
NAME OF CEO OF AGENCY PROVIDER, IF APPLICABLE	Betty Boop

DEFINITION OF NON-MEDICAL TRANSPORTATION TO ACCESS ADULT DAY SERVICES

"Non-medical transportation" means transportation that is used by waiver enrollees solely to access adult day support, vocational habilitation, supported employment-enclave, and/or supported employment-community services as specified by their individual service plan (ISP). Whenever possible, family, friends, neighbors or community agencies can provide this service without charge shall be used.

The following standards apply to each independent provider and each employee, contractor, and employee of a contractor of an agency provider who is engaged in a direct services position. Independent providers must submit evidence of the following standards upon application. Please check the box to indicate that the documentation is included.

☐ Hold valid American Red Cross or equivalent certification in First Aid

☐ Hold valid American Red Cross or equivalent certification in CPR

☐ Have completed eight hours of training that addresses the following topics:

- Overview of serving individuals with developmental disabilities
- Rights of individuals set forth in sections 5123.62 to 5123.64 of the Ohio Revised Code
- Overview of basic principles and requirements for providing HCBS waiver services
- Requirements of rule 5123-2-17-02 of the Ohio Administrative Code
- Universal precautions for infection control, including hand washing and the disposal of bodily waste

☐ Hold a valid driver's license as specified by Ohio law

☐ Have evidence of a negative testing for controlled substances by a laboratory certified for such testing

☐ Have a signed statement from a licensed physician declaring that he/she does not have a medical condition, a physical condition including an uncorrected vision and/or hearing impairment or a mental condition which could interfere with safe driving, safe passenger assistance, and the provision of emergency treatment activity or could jeopardize the health or welfare of individuals being transported. A person employed as a driver on the effective date of this rule may be deemed to meet the requirements of this paragraph when the provider maintains verification that a physical examination was completed at the time of the person's hire (if billing for per-trip rate only).

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

Each applicant billing the per-trip rate must initial the following to indicate your understanding and assurance to comply.

BB Transportation will only occur in a non-modified vehicle with a passenger capacity of nine or more; or a modified vehicle designed to transport one or more individuals sitting in wheelchairs and has permanent fasteners to secure the wheelchairs to the floor or side of the vehicle to prevent wheelchair movement, and that:

- Safety restraints are placed in the vehicle for the purpose of restraining the individual in the wheelchair;
- The vehicle is equipped with a stable access ramp or hydraulic lift; and
- On each day the vehicle is used to provide non-medical transportation services, the driver of the vehicle shall conduct and document inspection and testing of the lift or access ramp and wheelchair restraints prior to transporting a wheelchair-bound individual.

BB The following regulations will be maintained:

(a) Individuals will be in the vehicle during the times the provider bills for the per-trip rate.
(b) The vehicle has secure storage space for removable equipment and passenger property.
(c) The vehicle is equipped with a communication system that may include cellular communication capable of two-way communication.
(d) The vehicle is equipped with a fire extinguisher and an emergency first-aid kit that are safely secured.
(e) The applicant shall agree that on each day the vehicle is used to provide non-medical transportation services, the driver of the vehicle shall conduct and document a pre-trip inspection of lights, windshield washers/wipers, emergency equipment, mirrors, horns, tires, and brakes.
(f) Provide evidence of completion of at least an annual vehicle inspection of each vehicle by the Ohio State Highway Patrol safety inspection unit or a certified mechanic and proof that the vehicle is in good and working condition.
(g) Disclose evidence of liability insurance coverage, in an amount of not less than five hundred thousand dollars per occurrence and not less than five hundred thousand dollars in the aggregate, for any cause for which the provider would be liable.
(h) Disclose evidence of bodily injury and property damage insurance coverage with solvent insurers licensed to do business in the state for any loss or damage resulting from any occurrence arising out of or caused by the operation of the vehicle. The insurance plan shall insure each vehicle for the sum of not less than one hundred thousand dollars for bodily injury to or death of more than one person in any one accident and for the sum of fifty thousand dollars for damage to property arising from one accident.

BB Each driver, in accordance with Chapter 4507. of the Ohio Revised Code, shall:

(a) Possess a valid driver's license and be 18 years of age or older.
(b) Provide a signed statement from a licensed physician declaring that he/she does not have a medical condition, a physical condition including an uncorrected vision and/or hearing impairment, or a mental condition which could interfere with safe driving, safe passenger assistance, the provision of emergency treatment activity, or could jeopardize the health or welfare of individuals being transported. A person employed as a driver prior to the effective date of this rule may be deemed to meet the requirements of this paragraph when the provider maintains verification that a physical examination was completed at the time of the person's hire.
(c) Complete testing for controlled substances by a laboratory certified for such testing and be determined to be drug free prior to providing and billing for non-medical transportation waiver services. Controlled substance and alcohol testing shall occur within 10 hours following an incident when the certified provider, a contractor and/or employee of the certified provider, and/or an employee of the contractor was providing non-medical transportation waiver services and was involved in a motor vehicle accident and was the driver of the vehicle when:
    (i) The accident involves the loss of human life; or
    (ii) The driver receives a citation that was written within eight hours of the accident under state or local law for a moving traffic violation arising from the accident, if the accident involved bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or one or more motor vehicles incurred disabling damage as a result of the accident, requiring the motor vehicle to be transported away from the scene by a tow truck or other motor vehicle.
(d) Present a driver's abstract prepared by the bureau of motor vehicles no earlier than 14 days prior to the date of initial employment as a driver and at least once each calendar year thereafter. Persons having six or more points on their driving records are prohibited from providing non-medical transportation waiver services.

Each applicant billing the per-mile rate must initial the following to indicate your understanding and assurance to comply.

BB The applicant assures vehicle capacity of eight or fewer.

BB Calculation of the per-mile payment amount for a commute assures that each passenger in the vehicle shares equally in the total cost of the commute;

(a) Passengers include waiver enrollees and non-waiver enrollees for purposes of determining the number of individuals in the vehicle during the commute.
(b) The number of miles for each commute is calculated from the point where the first waiver enrollee riding in the vehicle is picked up and the point where the last waiver enrollee in the same vehicle is dropped off at his/her destination.
(c) When per-mile non-medical transportation services are provided and billed through the waiver, the provider shall not bill for homemaker/personal care, adult day support, vocational habilitation, supported employment-enclave, or supported employment-community waiver services provided by the driver of the vehicle during the time in which the commute occurs.

BB The following regulations will be maintained:

(a) The vehicle has storage space for removable equipment and passenger property.
(b) The vehicle is equipped with a communication system that may include cellular communication capable of two-way communication.
(c) The vehicle is equipped with a fire extinguisher and an emergency first-aid kit that are safely secured.
(d) The applicant shall agree that on each day the vehicle is used to provide non-medical transportation services, the first driver of the vehicle shall conduct and document a per trip inspection of lights, windshield washers/wipers, emergency equipment, mirrors, horns, tires, and brakes.
(e) Provide evidence of completion of at least an annual vehicle inspection and proof that the vehicle is in good working condition.
(f) The applicant shall agree to provide evidence of completion of at least an annual vehicle inspection of each vehicle by the Ohio State Highway Patrol safety inspection unit or a certified mechanic and proof that the vehicle is in good and working condition.
(g) The applicant shall disclose evidence of liability insurance coverage, in an amount of not less than five hundred dollars per occurrence and not less than five hundred thousand dollars in the aggregate, for any cause for which the provider would be liable.

(h) Disclose evidence of bodily injury and property damage insurance coverage with solvent insurers licensed to do business in the state for any loss or damage resulting from any occurrence arising out of or caused by the operation of a vehicle. The insurance plan shall insure each vehicle for the sum of not less than one hundred thousand dollars for bodily injury to or death of more than one person in any one accident and for the sum of fifty thousand dollars for damage to property arising from one accident.

BB Each driver, in accordance with Chapter 4507. of the Ohio Revised Code, shall:

(a) Possess a valid driver's license and be 18 years of age or older.

(b) Provide a signed statement from a licensed physician declaring that he/she does not have a medical condition, a physical condition including an uncorrected vision and/or hearing impairment, or a mental condition which could interfere with safe driving, safe passenger assistance, the provision of emergency treatment activity, or could jeopardize the health or welfare of individuals being transported. A person employed as a driver prior to the effective date of this rule may be deemed to meet the requirements of this paragraph when the provider maintains verification that a physical examination was completed at the time of the person's hire.

(c) Complete testing for controlled substances by a laboratory certified for such testing and be determined to be drug free prior to providing and billing for non-medical transportation waiver services. Controlled substance and alcohol testing shall occur within 10 hours following an incident when the certified provider, a contractor and/or employee of the certified provider, and/or an employee of the contractor was providing non-medical transportation waiver services and was involved in a motor vehicle accident and was the driver of the vehicle when:

(i) The accident involves the loss of human life; or

(ii) The driver receives a citation that was written within eight hours of the accident under state or local law for a moving traffic violation arising from the accident, if the accident involved bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or one or more motor vehicles incurred disabling damage as a result of the accident, requiring the motor vehicle to be transported away from the scene by a tow truck or other motor vehicle.

(d) Present a driver's abstract prepared by the bureau of motor vehicles no earlier than fourteen days prior to the date of initial employment as a driver and at least once each calendar year thereafter. Persons having six or more points on their driving records are prohibited from providing non-medical transportation waiver services.

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

Betty Boop
Signature of Independent Provider/Agency CEO Applicant

3/31/10
Date

Return completed application with supporting documentation to:
Ohio Department of Developmental Disabilities
Office of Provider Certification
30 East Broad Street, 13th Floor
Columbus, Ohio 43215
1-877-289-3636

Or email Provider.Certification@dmr.state.oh.us