

**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	Betty Boop
NAME OF CEO OF AGENCY PROVIDER, IF APPLICABLE	
STREET ADDRESS	123 N. Circle St.
CITY/STATE/ZIP	Anywhere, OH 55555
COUNTY	Ross
SOCIAL SECURITY NUMBER OF INDEPENDENT PROVIDER OR TAX ID NUMBER OF AGENCY PROVIDER	555-22-1234
AREA CODE & TELEPHONE NUMBER	740-555-1212
EMAIL ADDRESS	bboop@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.
<input type="checkbox"/> Adaptive and Assistive Equipment (IO waiver only)	
<input type="checkbox"/> Adult Day Support & Vocational Habilitation	
<input checked="" type="checkbox"/> Adult Foster Care (IO waiver only)	
<input type="checkbox"/> Environmental Accessibility Adaptations	
<input type="checkbox"/> Home-Delivered Meals (IO waiver only)	
<input checked="" type="checkbox"/> Homemaker/Personal Care	
<input checked="" type="checkbox"/> Informal Respite (L1 waiver only)	
<input type="checkbox"/> Institutional Respite	
<input type="checkbox"/> Interpreter (IO waiver only)	
<input type="checkbox"/> Non-Medical Transportation to access adult day services	
<input type="checkbox"/> Nutrition (IO waiver only)	
<input type="checkbox"/> Personal Emergency Response Systems (L1 waiver only)	
<input type="checkbox"/> Social Work (IO waiver only)	
<input type="checkbox"/> Specialized Medical Equipment and Supplies (L1 waiver only)	
<input type="checkbox"/> Supported Employment-Community & Supported Employment-Enclave	
<input checked="" type="checkbox"/> Transportation (L1 waiver only)	
<input checked="" type="checkbox"/> Transportation Mileage other than to access adult day services (IO waiver only)	

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

_____ 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

0/00/0000
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 Job and Family Services
Ohio Health Plans Provider Enrollment Application/Time Limited
Agreement For Individual Practitioners**

Submit completed signed application/enrollment 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

Complete all applicable items if you plan to bill Medicaid as an individual physician or non-physician practitioner. All physicians and non-physician practitioners who are members of a group must apply as individuals for Medicaid enrollment.

Individual Provider Types: - Required (Mark only ONE box to indicate your Provider Type.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Chiro/Mechanotherapist (37) | <input type="checkbox"/> Nurse Anesthetist/Anesthesiologist Assistant (73) | <input type="checkbox"/> Osteopath (22) |
| <input type="checkbox"/> Chiropractor (27) | <input type="checkbox"/> Nurse Midwife (71) | <input type="checkbox"/> Physical Therapist (39) |
| <input type="checkbox"/> Clinical Nurse Specialist (85) | <input type="checkbox"/> Nurse Practitioner (72) | <input type="checkbox"/> Physician (20) |
| <input type="checkbox"/> Dentist (30) | <input type="checkbox"/> Occupational Therapist (41) | <input type="checkbox"/> Pediatrician (38) |
| <input type="checkbox"/> Nurse, RN, LPN (38) | <input type="checkbox"/> Optician (75) | <input type="checkbox"/> Psychologist (42) |
| <input checked="" type="checkbox"/> Non-Agency Personal Care Aide (25) | <input type="checkbox"/> Optometrist (35) | <input type="checkbox"/> Waiver Service Provider (45) |

Provider Identification: - Required (Print or type entries.)

Name (First) Betty	(Middle Initial)	(Last) Boop	Title (M.D., D.O., etc.)
Social Security Number (ALL Individual Practitioners) 555-22-1234	You must attach a Signed W-9 form with individual's name, address, social security number, original signature, and date. Do not use GROUP tax ID number.		Employer Identification Number (incorporated individuals, etc.)
			DEA number

Address Information: - Required (Print or type entries.)

Physical Location of Practice/Business (Applicants: If more than one location, list Primary)

Building Name / OR / Department / OR / In care of Betty Boop			
Practice Address (Number, Street, Avenue, Route, etc. P.O. and Drop Boxes are not acceptable) 123 N. 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)

(If Address is not different from "Physical Location of Practice" address, leave blank)

Building Name / OR / Department / OR / In care of Betty Boop			
Address P.O. Box 123			Suite Number
City Anywhere	State OH	Zip Code (Zip + 4, if possible) 55555	

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

(If Address is not different from "Physical Location of Practice" address, leave blank)

Building Name / OR / Department / OR / In care of			
Address (P.O. and Drop Boxes are not acceptable)			Suite Number
City	State	Zip Code (Zip + 4, if possible)	

(For State Use Only)

Caution ALL blocks in the licensure section must be completed to avoid return of application/agreement

Licensure Information: (Print or type entries)

License number*	License Issuance Date (mm/dd/yyyy)	Current License Expiration Date* (mm/dd/yyyy)
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*You must attach copy of State Board License *You must attach copy of Renewal Card

Medicare Identification Information: Required for Physical/Occupational Therapists and Psychologists
If you are a participating Medicare provider, enter your Medicare information (Print or type entries)

PIN number (S Do not use LPI#)	CLA number*	DMERC number*
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*You must attach copy of the Medicare Certification bills *You must attach copy of CLA Certificate *You must attach copy of DMERC Certificate

National Provider Identifier:

If you have received your National Provider Identifier (NPI), and/or if you had a previous NPI, please report it here.

Current NPI number**	Previous NPI number	** You must attach a copy of the notice from the NPI Enumerator to verify the National Provider Identifier Number.
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Physician/Oral Surgeon Specialty Certification: (Complete only if Board Certified)

PRIMARY Specialty Type	Board Name	Certification Date (mm/dd/yyyy)
SECONDARY Specialty Type	Board Name	Certification Date (mm/dd/yyyy)

Enter any Ohio Medicaid 7-digit Group Provider Numbers you are Affiliated with:

1	2	3	4	5
6	7	8	9	10

Nurse Applicants: - Required (Print or type entries)

Do you have Prescriptive Authority? <input type="checkbox"/> YES <input type="checkbox"/> NO		Are you an APN Pilot Program Participant? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Certification Number*	Certification Date (mm/dd/yyyy)	Current Renewal Date* (mm/dd/yyyy)	
*You must attach copy of Certificate			
Do you have a Certificate of Authority? (NON PILOT PROGRAM PARTICIPANTS) <input type="checkbox"/> YES <input type="checkbox"/> NO		*You must attach copy of Renewal Card	
Certification Number*	Certification Date (mm/dd/yyyy)	Current Renewal Date* (mm/dd/yyyy)	
*You must attach copy of Certificate			
Specialty Certification Number*	Certification Date (mm/dd/yyyy)	Current Renewal Date* (mm/dd/yyyy)	
*You must attach copy of Certificate			
CRNA Certificate Number*	CRNA Recertification Date (mm/dd/yyyy)	CRNA Recertification Card Expiration Date (mm/dd/yyyy)	
*You must attach copy of Certificate			
FN/APN License number*	License Issuance Date (mm/dd/yyyy)	Current License Expiration Date* (mm/dd/yyyy)	
*You must attach copy of License			
	Master's Degree Certification Date (mm/dd/yyyy)	A Master's Degree in Nursing is an Ohio Medicaid requirement for all advanced practice nurses effective January 1, 2013.	
*You must attach copy of Certificate			

Optional Category of Service: (If you will provide an Optional Category of Service, mark your Provider Type, and mark the Categories of Service(s) you intend to provide.)

<input type="checkbox"/> Physician & Osteopath	<input type="checkbox"/> 30-Prescribed Drugs,	<input type="checkbox"/> 32-Supplies and Medical Equipment
<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> 30-Prescribed Drugs,	<input type="checkbox"/> 32-Supplies and Medical Equipment
<input type="checkbox"/> Dentist	<input type="checkbox"/> 30-Prescribed Drugs,	<input type="checkbox"/> 43-Physician Services
<input type="checkbox"/> Ophthalmist	<input type="checkbox"/> 30-Prescribed Drugs,	<input type="checkbox"/> 32-Supplies and Medical Equipment <input type="checkbox"/> 34-Eyeglasses

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(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 grant and may result in the loss of other contracts or grants with the State of Ohio.

Individual Practitioner Name and Title (please print):

Betty Boop, Provider

Individual Practitioner Initial: bb Date: 5-4-09

A copy of Executive Order 2007-01S can be found on our website at:
<http://jfs.ohio.gov/ohpl>

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.

Individual Practitioner Name and Title (please print):

Betty Boop, Provider

Individual Practitioner Initial: bb Date: 5-4-09

Occupational Therapy Practitioners only:

I attest that I am an independent Occupational Therapist and I am not associated with an institutional facility or a school system.

Individual Practitioner Name and Title (please print):

Individual Practitioner Initial: _____ Date: _____

(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 XX 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 417.435(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. This agreement is limited to 3 years from the effective date.

Individual Practitioner Name and Title (please print): Betty Bopp, Provider

Individual Practitioner Signature: Betty Bopp | Date: 5-4-09 (mm/dd/yyyy)

For State Use Only

Signature of Authorized Agent: _____ Date: _____ (mm/dd/yyyy)

(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		Label 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

- 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)

Betty Boop

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

TAXPAYER ID # (TIN):

555-22-1234

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

- CORPORATION PARTNERSHIP SOLE PROPRIETOR
- NON PROFIT INDIVIDUAL
- OTHER (PLEASE EXPLAIN) _____

INDUSTRY CLASSIFICATION:

STANDARD INDUSTRIAL CLASSIFICATION (SIC) CODE 00000

NORTH AMERICAN INDUSTRY CLASSIFICATION SYSTEM (NAICS) CODE 00000

SECTION 3 - PLEASE PROVIDE COMPLETE ADDRESS

ADDRESS: 123 N Circle Street COUNTY: ROSS

CITY: Anywhere STATE: OH ZIP CODE: 55555

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

ADDRESS:

[Empty address field]

CITY:

[Empty city field]

STATE:

[Empty state field]

ZIP CODE:

[Empty zip code field]

SECTION 5 - CONTACT INFORMATION AND PERSON TO RECEIVE PURCHASE ORDER

NAME:

[Empty name field]

WEB SITE:

[Empty web site field]

PHONE:

[Empty phone field]

FAX:

[Empty fax field]

E-MAIL:

[Empty e-mail field]

SECTION 6 - IS YOUR BUSINESS CURRENTLY 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:

bboop@hotmail.com

FAX:

[Empty fax field]

SECTION 9 - PLEASE SIGN & DATE

SIGNATURE:

Betty Boop

DATE:

00/00/0000

SECTION 10 - AGENCY CONTACT INFORMATION

AGENCY NAME:

[Empty agency name field]

PHONE NUMBER:

[Empty phone number field]

E-MAIL:

[Empty e-mail field]

COMMENTS:

[Empty comments field]

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

**Request for Taxpayer
Identification Number and Certification**

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

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

Business name, if different from above

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

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

City, state, and ZIP code
Nowhere, OH 55555

Requester's name and address (optional)

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
555 122 11234

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

- 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
- 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
- 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:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- 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 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 Booo		FIRST NAME Betty		MI
HOME ADDRESS 123 N. Circle St.				
CITY Anywhere	STATE OH	ZIP 55555	COUNTY Ross	
HOME PHONE 740-555-1212		WORK PHONE		

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

LAST NAME		FIRST NAME		MI
BUSINESS/ORGANIZATION NAME			PHONE	
BUSINESS ADDRESS				
CITY	STATE	ZIP	COUNTY	

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.

- Are you a member of an organization on the U.S. Department of State Terrorist Exclusion List? Yes No
- 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
- 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
- Have you solicited any individual for membership in an organization on the U.S. Department of State Terrorist Exclusion List? Yes No
- 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
- 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 Betty Bump
APPLICANT SIGNATURE

5-4-09
DATE

**PROVIDER CERTIFICATION APPLICATION ADDENDUM
HOMEMAKER/PERSONAL CARE**

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

NAME OF INDEPENDENT/AGENCY PROVIDER	Betty Boop
NAME OF CEO OF AGENCY PROVIDER, IF APPLICABLE	

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

00/00/0000
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

**PROVIDER CERTIFICATION APPLICATION ADDENDUM
TRANSPORTATION**

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

NAME OF INDEPENDENT/AGENCY PROVIDER	Betty Boop
NAME OF CEO OF AGENCY PROVIDER, IF APPLICABLE	

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 440.178(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.

BB 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.

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

_____ 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.

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

_____ 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

00/00/0000
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

**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	Betty Boop
NAME OF CEO OF AGENCY PROVIDER, IF APPLICABLE	

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.

BB 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.

_____ 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

00/00/0000
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



**PROVIDER CERTIFICATION APPLICATION ADDENDUM
ADULT FOSTER CARE**

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

NAME OF INDEPENDENT/AGENCY PROVIDER	Betty Boop
NAME OF CEO OF AGENCY PROVIDER, IF APPLICABLE	

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 approximate 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.

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

BB 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.

_____ 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.

_____ Agency providers of adult foster care may subcontract the provision of adult foster care services in accordance with paragraph (1) 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 Boop
Signature of Independent Provider/Agency CEO Applicant

00/00/0000
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



PROVIDER CERTIFICATION APPLICATION ADDENDUM INFORMAL RESPITE

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

NAME OF INDEPENDENT LIMITED PROVIDER	Betty Boop
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DEFINITION OF INFORMAL RESPITE

"Informal respite" means services provided by a limited provider to individuals unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Informal respite may be provided in the individual's home or place of residence, home of a friend or family member, or sites of community activities. For purposes of this service, "family member" means parent, brother, sister, spouse, son, daughter, grandparent, aunt, uncle, cousin, or guardian of the individual who has developmental disabilities. "Family member" also means a person acting in a role similar to those specified even though no legal or blood relationship exists, if the individual who has developmental disabilities lives with the person and is dependent on him/her to the extent that if supports were withdrawn, another living arrangement would have to be found; the person shall verify the relationship by signature. The benefit limitation for this service, institutional respite, homemaker/personal care, and transportation combined shall not exceed five thousand dollars annually.

"Limited provider" means a person who is known to the individual, is selected by the individual or the individual's guardian, and who provides informal respite only to the individual or to multiple individuals who live in the same family setting.

The following standards apply to each limited provider, except when the limited provider is providing services only to his/her own family member. Applicants must submit evidence of the following standards upon application. Please check the box to indicate that the documentation is included, or check the box to indicate that the applicant shall provide services only to his/her own family member.

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

OR

I shall provide informal respite only to my own family member (provide name of and applicant's relationship to individual being served)

Name of individual being served:	
Applicant's relationship to individual being served:	

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

BB The limited provider shall communicate with service and support administration staff and the responsible family member for the purpose of coordinating activities to ensure that services are provided to the individual in accordance with the ISP and intended outcomes.

BB The limited provider shall receive orientation and training by the responsible family member, prior to the delivery of services, about activities required to meet the needs and preferences of the individual being served, including training stipulated for the individual in his/her individual service plan (ISP) and other information related to health and welfare needs of the individual.

BB The limited provider shall annually receive training by the responsible family member, about the activities required to meet the needs and preferences of the individual being served, including any training stipulated for the individual in his/her ISP and other information related to health and welfare needs of the individual.

BB The limited provider shall comply with the reporting requirements in rule 5123:2-17-02 of the Ohio Administrative Code relating to incidents adversely affecting health and safety.

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

- BB** Upon request by the Ohio Department of Developmental Disabilities, the Ohio Department of Job and Family Services, or the county board of developmental disabilities, the limited provider shall present written documentation from the individual's ISP to demonstrate that he/she has been selected by the individual or the individual's guardian to provide informal respite services.
- BB** The limited provider shall maintain documentation from the Department of the limited provider's certification.
- BB** Except in the case of multiple individuals enrolled in the HCBS Level One waiver who live in the same family setting, the limited provider shall not provide informal respite to more than one individual.

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 Limited Provider Applicant

00/00/0000
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
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Or email Provider.Certification@dmr.state.oh.us