Ohio | Department of Developmental Disabilities

PROVIDER CERTIFICATION APPLICATION ADDENDUM
SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

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

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

DEFINITION OF SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

"Specialized medical equipment and supplies" means those specialized medical equipment and supplies that include devices, controls, or appliances, specified in the individual's ISP, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the state plan and shall exclude those items that are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design, and installation. The benefit limitation for this service, personal emergency response systems, and environmental accessibility adaptations combined shall not exceed six thousand dollars over a three-year period.

☐ **The applicant must submit documentation (e.g., letters from previous customers, resume outlining experience, or contractor's license) verifying experience in providing the service. Please check the box to indicate that the documentation is included.**

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

_____ The provider shall meet all applicable state and local regulations that apply to the operation of the provider's business or trade.

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

_____ The agency provider shall enter into a written contract when working with a subcontractor.

_____ The agency provider shall provide notification to the county board of developmental disabilities of all subcontracts for specialized medical equipment and supplies.

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.

_____ _____

Signature of Independent Provider/Agency CEO Applicant 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