# Community First Choice (CFC) Provider Application Instructions


**Department of Health and Mental Hygiene**
**Medical Care Programs**

**Revised May 2014**

## Table of Contents

# Community First Choice (CFC) Provider Application Instructions

The Maryland Medical Assistance Program (Program) is working to ensure that all CFC providers – agencies and independent providers – that want to enroll as a Medicaid fee-for-service provider receive appropriate application forms and technical assistance.

The Program(s) is designed to offer certain community-based services to individuals who meet an institutional level of care as an alternative to institutional placement. Self-direction for Medicaid participants is an important part of CFC. Participants will have the ability to recruit, hire, train and supervise their personal assistance providers along with controlling a flexible budget for personal assistance. In addition, Medical Assistance Personal Care (MAPC) providers are now required to have CPR and First Aid certification to be eligible to participate in the Program.

| **CFC Services** | **Community Options Waiver** |
|---|---|
| Accessibility Adaptations | Assistive Living |
| Assistive Technology | Behavioral Health Consultation |
| Consumer Training | Family Training |
| Environmental Assessments | Medical day care |
| Home Delivered Meal | Nutrition/Dietitian Care |
| Personal Assistance Services | Senior Center Plus |
| Personal Emergency Response Systems | |
| Supports Planning | |
| Transition Service | |
| Nurse Monitoring | |
| Items or services that substitute for Human Assistance | |

Additional information is detailed on our website at: https://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Long%20Term%20Care%20Forms.aspx.

Enclosed you will find a generic Medical Assistance Provider application form. **Do not complete this application if you are already enrolled with the Medical Assistance Program as provider type 76 (Community Options Waiver Provider).**

Agencies please return the Provider Application form, Provider Agreement, and OHCQ Certification and/or other required documents to:

Provider Enrollment
P.O. Box 17030
Baltimore, MD 21203

Agencies: After receiving your Medical Assistance application, Medicaid site surveyors will complete an unannounced site review. Site visits are federally mandated and independent of any previous OHCQ site reviews conducted. Providers must demonstrate compliance with the COMAR regulations during this process. Your actual enrollment as a Medical Assistance provider will not occur until after the site visit is complete.

Independent providers please return completed application to:

CFC/DHMH
201 W. Preston Street, Rm 136
Baltimore, MD 21201

*If approved as a Medical Assistance provider,* ***Medicaid will send notification with your assigned provider number and approved begin date. At that time, you can bill for services that have been approved by Maryland Department of Health and Mental Hygiene.*** *Once you have mailed your complete application, you can call the CFC Provider Enrollment Hotline with any questions regarding the status of the enrollment process:*

CFC Provider Enrollment
(410) 767-1739

**Note**: Provider information and billing instructions can be located on our website at:
https://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx

And Maryland regulations for Maryland Medical Care Programs can be found at:
http://www.dsd.state.md.us/comar/subtitle_chapters/10_Chapters.aspx#Subtitle09

Your interest in becoming a Maryland Medical Assistance Provider is greatly appreciated.

**REQUIREMENT A**
**PROVIDER APPLICATION FORM**

## SECTION #1

APPLICATION TYPE

Check the appropriate box.

**Do not complete this application if you are already enrolled with the Medical Assistance Program as a provider type 76 (Community Options Waiver provider)**

NPI: Not Applicable

I AM APPLYING AS A …PLEASE CHECK ONE

**Agency Providers** – Please check **Facility/Institution/Business/Agency**

**Independent Providers** – Please check **Individual**

REQUESTED ENROLLMENT BEGIN DATE (TOP RIGHT)

Enter the date you are requesting for enrollment. **Note**: Maryland Medicaid will not backdate your enrollment more than (3) months prior to receiving your application.

## SECTION #2

PROVIDER INFORMATION

Please complete all applicable information. The Program completed the "Provider Type Code" for you with a Provider Type of 76.

For "county code", please use the codes below.

**Agency Providers** – Select the county code where your business is located.

**Independent Providers** – Select the county code where you live.

| COUNTY CODE |
|---|
| 01 – Allegany |
| 02 – Anne Arundel |
| 03 – Baltimore County |
| 04 – Calvert |
| 05 – Caroline |
| 06 – Carroll |
| 07 – Cecil |
| 08 – Charles |
| 09 – Dorchester |
| 10 – Frederick |
| 11 – Garrett |
| 12 – Harford |
| 13 – Howard |
| 14 – Kent |
| 15 – Montgomery |
| 16 – Prince Georges |
| 17 – Queen Anne's |
| 18 – St. Mary's |
| 19 – Somerset |
| 20 – Talbot |
| 21 – Washington |
| 22 – Wicomico |
| 23 – Worcester |
| 30 – Baltimore City |
| 99 – Other State |

## SECTION #3

LICENSE/PERMIT INFORMATION

Not Applicable.

## SECTION #4

PRACTICE INFORMATION

**Agency Providers** – Please check **99-Agency/Group**

**Independent Providers** – Please check **30- Independent**

**Other** – Please check **99-Other**

## SECTION #5 – SECTION #8

Not applicable.

## SECTION #9

ALTERNATIVE ADDRESS INFORMATION

Complete if pay-to or correspondence addresses are different than program address.

Would you prefer to receive electronic correspondence, including remittance advices, in lieu of paper, when available? Please check the appropriate box and make sure you have included your email address on the first page of the application (SECTION 2).

## SECTION #10

OTHER PRACTICE LOCATION INFORMATION

Please fill in if applicable

## SECTION #11

Not applicable.

## SECTION #12

AUTHORIZATION

**Agency Providers** – Please have administrator or authorized representative date, sign and print name as indicated.

**Independent Providers** – Please complete authorize signature and date.

## PROVIDER APPLICATION PRACTITIONER AND GROUP ADDENDUM FORM

Not applicable.

## PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM

**Agency Providers** – please enter the provider name and address. Please complete the form from A to D and have administrator or authorized representative date and sign as indicated.

**Independent Providers** – Please indicate the provider name and address.

## REQUIREMENT B
## PROVIDER AGREEMENT FOR PARTICIPATION IN MARYLAND MEDICAL ASSISTANCE PROGRAM FORM

**All providers must complete and sign the provider agreement.**

**Page 1:** Print your name at the top of page in the blanks provided.

**Page 6:** Sign your name and date, print your name and date, then print your address and date.

## REQUIREMENT C
## APPLICATION ADDENDUM

**Part I –** Please check whether you are "self-employed" (independent) or an agency.

**Part II – Services:** Select the services you intend to provide.

**Part III – Service Areas:** Check the area(s) you intend to serve.

**Part IV – General Conditions for Provider Participation:** Providers are required to write your initials beside each numbered condition then sign and date at the bottom in the blanks provided. Please have CFC division date, sign and print name as indicated.

**REQUIREMENT D**
**ADDITIONAL DOCUMENTATION**

**For Agencies:**

- Copy of current Residential Services Agency License from Office of Health Care Quality (OHCQ) Set up an agency account with the Criminal Justice Information System (CJIS) to perform a criminal history record check for all aides.
    - CJIS will directly send the results to Medicaid.
    - Aides and registered nurses must also submit:
        - Copy of social security card or proof of legal eligibility for employment in Maryland
        - Copy of driver's license or birth certificate
        - Copy of CPR and Basic First Aid credentials
        - Copy of current CJIS report

**For Independent Providers:**

- Copy of social security card or proof of legal eligibility for employment in Maryland
- Copy of driver's license or birth certificate
- Copy of CPR and Basic First Aid credentials

**Other Providers/Services:**

**Accessibility Adaptations + Personal Emergency Response + Assistive Technology**

- Proof that you are the store, vendor, or the company, who sells, rents, installs, services, runs the device or service.
- Copy of appropriate Residential Service Agency license.
- Copy of appropriate Tax ID, Trader, MHIC licensing and proof of Liability Insurance.

**Assistive Living**

- Copy of license as physician registered nurse or practical nurse
- Resume –reflecting an individual with 3 years experience in direct patient care in a private home, certified home or health related facility

**Behavorial Health Consultation**

- Copy of license as Psychologist, RN, or LCSW

**Consumer Training**

- Copy of current resume demonstrating experience developing and implementing skills that incorporate a consumer-directed philosophy of services

**Environmental Assessment**

- Copy of license as occupational therapist, or agency or professional group employing a licensed occupational therapist.
- Sample assessment form.
- Copy of driver's license or state issued valid photo identification.

**Family Training**

- Copy of current license as Registered Nurse, Occupational Therapist, Speech Pathologist, or Physical Therapist
- Copy of agency license which employs or contracts with a licensed professional listed above (self-employed professionals listed above do not require agency license)

**Home Delivered Meals:**

- Home Delivered meals: Proof of food service license issued by the local health department in accordance with COMAR 10.15..03

**Items or Services that Substitute for Human Assistance/ Home Delivered Meals/Assistive Devices,Equipment or Technology**

- Copy of appropriate Residential Service Agency license.
- Copy of appropriate Tax ID.

**Nutrition/Dietitian Services**

- Copy of Dietitian or Nutritionist License in accordance with COMAR 10.56.01

**Senior Center Plus**

- Copy of license as a health professional or license social worker
- Meet all local and State requirements to operate as a nutrition site
- Resume-reflecting 3 years experience in direct patient care at an adult day care center, nursing facility or health related facility

## APPENDIX 1: CRIMINAL BACKGROUND CHECKS FOR INDEPENDENT PROVIDERS ONLY

The CJIS Application is enclosed the application packet. Independent providers must answer all the questions on the application. **(NOTE: Agencies are NOT permitted to use this CJIS Application.)**

Take the LiveScan Pre-Registration Application to an authorized fingerprinting provider. The following locations are the ONLY authorized locations. Medicaid does not accept CJIS reports from other agencies not listed or copies from previous employers.

**Main Location for CJIS Fingerprinting Service**

| ADDRESS | PHONE | HOURS of OPERATION |
|---|---|---|
| **6776 Reisterstown Road**<br>**(West side of Reisterstown Road Plaza Mall)**<br>**Ste 102 (first floor)**<br>**Baltimore, MD. 21215** | **410-764-4501**<br>**1-888-795-0011 (toll free)** | **Monday-Friday 8:30-5pm** |

**The following locations are available by appointment only. To make an appointment, call 410-764-4501 or 1-888-795-0011 (toll free)**

| AGENCY | ADDRESS |
|---|---|
| **Motor Vehicle Administration-Bel Air** | **501 West MacPhail Road**<br>**Bel Air, MD. 21014** |
| **Motor Vehicle Administration-Frederick** | **1601 Bowman's Farm Road**<br>**Frederick, MD. 21701** |
| **Motor Vehicle Administration-Waldorf** | **St. Charles Business Park**<br>**11 Industrial Park Drive**<br>**Waldorf, MD. 21801** |
| **Motor Vehicle Administration-Salisbury** | **251 Tilghman Road**<br>**Salisbury, MD. 21801** |
| **Motor Vehicle Administration-Glen Burnie** | **6601 Ritchie Hwy, N.E.**<br>**Glen Burnie, MD. 21062** |

There is **no fee** required for the background check as long as you use the enclosed LiveScan Application, which has Medicaid's authorization number.

You will receive a copy of your criminal history in the mail. Medicaid will also receive a copy of the same report. **You do not need to send in the copy you get in the mail.**

For questions concerning this procedure, please contact Department of Public Safety and Correctional Services directly at 410-764-4501 or 1-888-795-0011.

# *STATE OF MARYLAND*

## *DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES*

### *CRIMINAL JUSTICE INFORMATION SYSTEMS – CENTRAL REPOSITORY*

## LIVESCAN PRE-REGISTRATION APPLICATION

**APPLICANT INFORMATION** *(PLEASE TYPE OR PRINT CLEARLY)*

| | | | |
|---|---|---|---|
| Name: | | | |
| Date of birth: | SSN: | Gender: ☐ Male ☐ Female *(Please check)* | |
| Height: ft. inches | Weight: lbs. | Eye Color: | Hair Color: |
| Race: ☐ Black ☐ White ☐ )Asian/Pacific Islander ☐ Native American ☐ Other *(Please check)* | | | |
| Place of Birth: | | Citizenship: | |
| Current address: | | | |
| City: | | State: | ZIP Code: - |
| Daytime Phone: | Evening Phone: | Driver's License #: | |

**AGENCY INFORMATION**

| | |
|---|---|
| Agency Authorization #: 1400000011 | |
| ORI # (if required): | Reason fingerprinted? |
| Position Applied for: | |

Request Type: *(Choose one ONLY)*

- ☐ Adult Dependent Care
- ☐ Attorney/Client
- ☐ Child care
- ☐ Criminal Justice
- ☐ Gold Seal/ Adoption
- ☐ Gold Seal/Letter/VISA
- ☐ Government Employment
- ☐ Government Licensing or Certification
- ☐ Immigration/VISA
- ☐ Individual Challenge
- ☐ Individual Review
- ☐ MSP Licensing
- ☐ Private Party Petition
- ☐ Public Housing

**Mail Response to:**
(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name: _____

Address: _____

City, State, Zip code: _____