DDA PROVIDER APPLICATION

For (1) new providers and (2) existing providers who wish to provide new services in the Family Supports and Community Supports Waivers, and the Community Pathways Renewal

I. BACKGROUND INFORMATION

a) **Application is for** *(select one)* ☐ **An Individual applicant** ☐ **Business/Agency** ☐ **OHCDS**

b) **Type of application** *(select one)* ☐ **Initial** ☐ **Renewal** ☐ **Request to Add New Service**
☐ **Other** (please specify)

c) **Services are proposed for** *(select one)* ☐ **Children only** ☐ **Adults only** ☐ **Both children and adults**

d) **Proposed Services in Waiver(s)** ☐ **Community Pathways** ☐ **Community Supports** ☐ **Family Supports**

e) **Applicant's Name or Name of Business/Agency (Doing Business As)**

f) **Name of Parent Company** (If applicable) (See Attachment 1)

g) **Applicant or Business/Agency Address**

h) **Telephone Number**

i) **Business Email Address**

j) **Applicant or Business website address**

k) **Do you have a National Provider Identifier?** ☐ yes ☐ no ☐ not applicable. If yes, provide number
(See Attachment 2)

l) **Do you have a Medicaid Provider Number?** ☐ yes or ☐ no If yes, provide number
(See Attachment 3)

m) **Do you have Business Tax ID Number?** ☐ yes or ☐ no If yes, provide number
(See Attachment 4)

n) **How is your Business/Agency organized?** ☐ **for profit or** ☐ **non-profit**

o) **Is your Business/Agency incorporated?** ☐ yes or ☐ no

If yes, please attach a copy of the Articles of Incorporation or Articles of Organization for your business (See Attachment 5).

p) **Is your Business/Agency a Minority Owned Business (MBE)?** (optional) ☐ yes or ☐ no

q) **Is your Business/Agency a Disadvantaged Business Enterprise (DBE)? (optional)** ☐ yes or ☐ no

r) **Primary Contact Information** (Include Director and Billing Contacts)

1. **Name and Position (Director/CEO)**

   Address

   Phone Number **Fax Number**

   Email Address

2. **Name and Position (Billing Contact/CFO)**

   Address

   Phone Number **Fax Number**

   Email Address

3. **Name and Position (Board of Directors Chairperson/President)**

   Address

   Phone Number **Fax Number**

   Email Address

II. PROPOSED AND CURRENT SERVICES

A. Check the Services/Supports for which DDA approval is sought.

***Note: Effective 1/1/2018, providers may only be approved to render new support and services in DDA's waivers only in locations/sites which meet the Community Settings Rule**. Providers may be enrolled to provide the current supports and services in which they are licensed and/or have been approved to render only if a transition plan has been submitted and approved by the DDA which ensures compliance to the Community Settings Rule required by the federal mandate. The DDA will complete an onsite assessment to grant Community Settings Rule compliance. All services under the Community Supports and Family Supports Waivers must meet the Community Setting Rule.*

1. Please Indicate

☐ Individual Applicant

☐ Non-Licensed Agency

☐ Licensed Agency/OHCDS

2. Select Services

☐ **DDA-Approved Behavioral Supports**
- Behavioral Assessment
- Behavioral Plan
- Behavioral Consultation
- Behavioral Support Implementation Services

☐ **DDA-Approved Community Development Services**

☐ **DDA-Approved Employment Services**
- Discovery
- Job Development
- Follow-Along Supports
- Ongoing Job Supports
- Coworker Employment Supports
- Customized Self-Employment

☐ **DDA-Approved Family Supports Provider**
- Family and Peer Mentoring Supports
- Family Caregiver Training and Empowerment Services
- Participant Education, Training and Advocacy Supports

☐ **DDA-Approved Fiscal Management Services**

☐ **DDA-Approved Housing Supports**

☐ **DDA-Approved Nursing**
- Nursing Consultation Services
- Nurse Health Case Management Services
- Nurse Health Case Management and Delegation Services

☐ **DDA-Organized Healthcare Delivery System**
- Assistive Technology and Services
- Environmental Assessment
- Environmental Modification
- Transition Services
- Transportation
- Vehicle Modification
- Rent Live-in Caregiver Support

☐ **DDA-Approved Personal Supports**

☐ **DDA-Approved Respite Care**
- Respite Care Services
- Respite Care Services - Camp

☐ **DDA-Approved Shared Living**
- Matching Services
- Host Home Stipend

☐ **DDA-Approved Supported Living**

Services continued on next page

☐ **DDA-Approved Remote Electronic Monitoring**	☐ **Licensed DDA Community Residential Services** - Community Living – Group Home - Community Living – Group Home Trial Experience	☐ **Licensed DDA Community Residential Enhanced Supports Services** - Community Living – Enhanced Supports - Community Living – Enhanced Supports Trial Experience
☐ **Licensed DDA Day Habilitation Services** *Community Pathways Waiver Only*	☐ **Licensed DDA Day Habilitation Services (CSR Compliant)** *Required for Community Supports and Family Supports Waivers*	☐ **Licensed DDA Target Case Management Services**
☐ **Licensed DDA Vocational Services** *Community Pathways Waiver* - Career Exploration – Facility Based - Career Exploration – Large Group - Career Exploration – Small Group	☐ **Licensed DDA Vocational Services (CSR Compliant)** *Community Supports and Family Supports Waivers* - Career Exploration – Facility Based - Career Exploration – Large Group - Career Exploration – Small Group	**Other Existing Services (to be phased out in July 2019):** ☐ Supported Employment ☐ Employment Discovery & Customization

B. Do you have an application pending approval to provide services/supports to DDA waiver participants?
☐ yes or ☐ no If yes, please indicate proposed licensed, OHCDS, and/or DDA-approved services.

C. Please indicate the licensed, OHCDS, and DDA-Approved services you have been authorized to provide and/or are currently providing to DDA waiver participants.

D. Check the area(s) where services/supports (current and proposed) will be provided (check all that apply)

Central Maryland
- ☐ Anne Arundel County
- ☐ Baltimore City
- ☐ Baltimore County
- ☐ Harford County
- ☐ Howard County

Eastern Shore
- ☐ Caroline County
- ☐ Cecil County
- ☐ Dorchester County
- ☐ Kent County
- ☐ Somerset County
- ☐ Talbot County
- ☐ Queen Anne's County
- ☐ Wicomico County
- ☐ Worcester County

Southern
- ☐ Calvert County
- ☐ Charles County
- ☐ Montgomery County
- ☐ Prince George's County
- ☐ St. Mary's County

Western
- ☐ Allegany County
- ☐ Carroll County
- ☐ Frederick County
- ☐ Garrett County
- ☐ Washington County

III. EXPERIENCE AND TRAINING

A. Applicant's Education, Relevant Work/Life Experiences and Training

(DDA *Licensed and Approved Providers can skip this section if submitting a renewal application. If this is an initial application for a business/agency or an application for approval of a new service(s) for a DDA Licensed or Approved Provider, this section may only be skipped if a resume is provided which demonstrates compliance with experience requirements. Individual Applicants must complete this section.*

Do you have a high school diploma? ☐ yes or ☐ no or GED ☐ yes or ☐ no

Name of high school or GED Program Dates Attended

Address

Name of College or University

Address

Dates Attended	Major	# of credits	Degree Earned (yes or no)	Type of Degree & Area (Submit copy as Attachment 6)

Name of College or University

Address

Dates Attended	Major	# of credits	Degree Earned (yes or no)	Type of Degree & Area (Submit copy as Attachment 6)

Relevant Work and/or Life Experiences and Skills Please list all relevant work and life experiences starting with your most recent experience. If more space is required, you may attach additional pages and/or your resume to this application. DDA will consider whether experience was full or part time, based on the number of years, and nature and intensity of needs of persons served against applicable eligibility criteria.

Date (Month/Year) Years Months Full-time ☐ Part-time ☐
From
To

Company Name

Address

Supervisor's Name and Title

Job Title

Telephone Number

Email address

Duties

Date (Month/Year) Years Months Full-time ☐ Part-time ☐
From
To

Company Name

Address

Supervisor's Name and Title

Job Title

Telephone Number

Email Address

Duties

B. Relevant Licenses, Certifications and Specialized Trainings Provide type, number, expiration date(s), and grantor and submit copy(ies) as per Attachment 7. You must include current CPR and First Aid trainings. Business/Agency applicants can skip this item and complete the Business/Agency Questionnaire and Information Form, Section IB6.

IV. ADDITIONAL APPLICANT OR BUSINESS/AGENCY INFORMATION

A. ARE YOU THE SOLE OWNER OF THE BUSINESS?

☐ yes or ☐ no

If yes, provide your social security number.

If no, please indicate your role and provide for each direct or indirect owner their full legal names, dates of birth, addresses, telephone numbers, email addresses, and social security numbers and label information requested as Attachment 8.

B. HAVE YOU OBTAINED THREE (3) PROFESSIONAL REFERENCES ATTESTING TO YOUR ABILITY TO DELIVER THE SERVICE/SUPPORT IN WHICH APPROVAL IS SOUGHT?

☐ yes or ☐ no

If yes, please submit each professional reference as Attachment 9.

Unless requesting a new service, DDA- Approved and Licensed Providers are not required to provide the references and are exempt from this requirement.

Exempt from requirement ☐ yes or ☐ no

C. IS YOUR BUSINESS/AGENCY CREDENTIALED, ACCREDITED OR CERTIFIED?

☐ yes or ☐ no

If yes, provide the name of accrediting body, license or certification number, state that issued the credential, accreditation, or certification and service(s) that is accredited and submit as Attachment 10.

D. DO YOU OR THE BUSINESS/AGENCY HAVE ANY DISTINCT SPECIALTY SERVICES, SUPPORTS, AND/OR EXPERIENCES WHICH MAY DIFFERENTIATE YOUR PROGRAM FROM OTHER PROVIDERS SERVING INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES?

☐ yes or ☐ no

If yes, please explain the specific information in your program service plan (Attachment 17) or add an additional page if you are applying as an individual applicant.

1. Applicants for Children's Licensure should explain training, skills and experience in providing services to children, and differentiate children's needs from adult's needs.
2. Applicants proposing to serve adults should explain training, skills, and experience in providing services for adults.
3. Behavioral Support Provider applicants should identify training and experience in applied behavior analysis, completing functional analyses and/or functional assessment, and behavior plans, and attach examples of developed plans.
4. Nursing Provider applicants should include training and experience in completing Health Risk Screening Tools, Nursing Assessments, providing Health Case Management, supervision of CNAs and CMAs, and treating individuals with chronic health care conditions. Please identify screening tools and assessments used.

E. DO YOU OR THE BUSINESS/AGENCY HAVE GENERAL COMMERICIAL LIABILITY INSURANCE?

☐ yes or ☐ no

If yes, specify the vendor, policy number and coverage dates submit this information and copies of coverage pages and label as Attachment 11.

F. DO YOU HAVE AUTOMOBILE INSURANCE FOR ALL CARS WHICH WILL BE USED TO CONDUCT BUSINESS?

☐ yes or ☐ no

If no, please explain. If yes, specify the vendor, policy number and coverage dates submit this information and copies of coverage pages as Attachment 12.

G. ARE YOU OR THE BUSINESS/AGENCY CURRENTLY APPROVED OR LICENSED, OR HAVE YOU OR THE BUSINESS/AGENCY BEEN APPROVED OR LICENSED IN THE LAST FIVE (5) YEARS TO PROVIDE SERVICES WITH ANY OTHER STATE OF MARYLAND OR OUT-OF-STATE AGENCY?

☐ yes or ☐ no

If yes, please specify approved/licensed services, population served and submit a copy of license. Also submit current and prior licensing reports issued within 10 years from any in-state or out-of-state entity including deficiency reports and compliance records and label as Attachment 13.

Note: During evaluation of your application, DDA may request that you provide for review OHCQ deficiency reports regarding DDA licensed services funded by business/agency during the last 10 years.

H. HAVE YOU OR THE BUSINESS/AGENCY BEEN AWARDED ANY CONTRACTS AND/OR FUNDING TO PROVIDE LICENSED OR NON-LICENSED SERVICES/SUPPORTS IN THE LAST FIVE (5) YEARS TO ANY STATE OF MARYLAND OR OUT-OF-STATE AGENCY?

☐ yes or ☐ no

If yes, please specify the nature, amount of services, population served and term dates, if applicable. If you or the business/agency has provided services in Maryland and another state, but no longer do so, please explain why you no longer provide those services.

I. EXCLUDING A BOARD OF DIRECTORS, DO YOU HAVE ANY OFFICER, INDIVIDUAL(S)/CONSULTANT(S) PAID OR UNPAID WHO HAS BEEN APPOINTED TO MAKE DECISIONS RELATED TO POLICIES, ACTIVITIES, AND THE SERVICES AND SUPPORTS YOU WILL PROVIDE TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES?

☐ yes or ☐ no

If yes, please explain.

J. DESCRIBE HOW YOU OR THE BUSINESS/AGENCY WILL SUPPORT INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES TO LIVE A LIFE AS DIVERSE AND ENRICHING AS OTHERS LIVING IN THEIR COMMUNITIES. (Please add an additional page if needed).

K. DO ALL LOCATIONS IN WHICH NEW SUPPORTS/SERVICES ARE PROPOSED TO BE PROVIDED MEET THE FEDERAL COMMUNITY SETTINGS RULE?

☐ yes or ☐ no

If no, please specify sites which do not, and indicate if you have a transition plan for eventual compliance approved by DDA? For settings to meet the Community Settings Rule the DDA must complete an onsite assessment and grant compliance approval.

L. WILL CURRENT SERVICES IN WHICH RENEWAL FOR DDA-APPROVED OR LICENSED SERVICES IS REQUESTED BE PROVIDED IN LOCATIONS WHICH MEET THE FEDERAL COMMUNITY SETTINGS RULE?

☐ yes or ☐ no

If no, do you have a transition plan which has been approved by DDA? ☐ yes or ☐ no

Please indicate the date your transition plan was approved and attach a copy of your approval letter.

M. DESCRIBE HOW YOU OR THE BUSINESS/AGENCY WILL ENSURE THAT INDIVIDUALS WILL HAVE INPUT REGARDING THE SERVICES/SUPPORTS THAT YOU PROVIDE. (Please skip this question if you are a Business/Agency applicant and complete the Business/Agency Questionnaire and Information Form).

N. ARE YOU OR IS YOUR BUSINESS/AGENCY IN GOOD STANDING WITH THE IRS AND/OR THE MARYLAND STATE DEPARTMENT OF ASSESSMENTS AND TAXATION?

☐ yes or ☐ no

If no, please explain. If application is for renewal of DDA Approval or License to render current services and supports, attach completed IRS Form 990 for the previous year if business is a non-profit. If business is for profit, attach completed Form1120. Label all information as Attachment 14. Information will be kept confidential and may be disclosed only in accordance with the provisions of the Maryland Public Information Act, General Prov. Art., Title 4, Md Ann. Code.

O. DO YOU OR YOUR BUSINESS/AGENCY HAVE ANY OUTSTANDING DEBTS TO OR DISALLOWANCES FROM DDA, OTHER STATE AND/OR FEDERAL AGENCIES?

☐ yes or ☐ no

If yes, please explain.

P. HAVE YOU, YOUR BUSINESS/AGENCY, CEO, OWNER, AND/OR OTHER ADMINISTRATORS OF YOUR BUSINESS/AGENCY EVER BEEN DISCIPLINED IN A MANNER WHICH HAS RESULTED IN SANCTIONS, A REPRIMAND, SUSPENSION, AND/OR EXPULSION FROM PROVIDING DDA- FUNDED SEERVICES OR FROM PARTICIPATING IN A STATE, FEDERAL, OR LOCAL PROGRAM OR CONTRACT (I.E., MEDICAID AND/OR MEDICARE), OR PRIVATE PROGRAM?

☐ yes or ☐ no

If yes, please explain.

Q. HAVE YOU, YOUR BUSINESS/AGENCY, OWNER, CEO, AND/OR OTHER ADMINISTRATORS OF YOUR BUSINESS BEEN AFFILIATED WITH ANY PROGRAM PROVIDING HEALTH CARE THAT HAS BEEN PLACED ON THE MEDICAID EXCLUSION LIST?

☐ yes or ☐ no

If yes, please explain.

R. HAVE YOU, YOUR BUSINESS/AGENCY, CEO, BUSINESS OWNER, AND/OR OTHER ADMINISTRATORS OF YOUR BUSINESS EVER BEEN CONVICTED OF A CRIMINAL OFFENSE, INCLUDING ANY PROGRAM UNDER TITLE 18, 19 or 20 0F THE SOCIAL SECURITY ACT?

☐ yes or ☐ no

If yes, please explain providing detailed information about the conviction including but not limited to: date, state, county, court, nature, and type of offense or violation, and penalty imposed. (Please attach required background checks for the applicant, CEO, Manager(s), Supervisor(s) and Business Owner(s) and label all information as Attachment 15.)

S. IF YOU PROPOSE TO SERVE CHILDREN, DO YOU OR YOUR BUSINESS/AGENCY CEOs, MANAGERS, SUPERVISORS, OR OWNERS OF YOUR BUSINESS WHO WILL HAVE DIRECT ACCESS TO CHILDREN HAVE CHILD PROTECTIVE CLEARANCE(S)?

☐ yes or ☐ no *If no, please explain. Please attach required Child Protective Clearance(s) as applicable for the applicant, CEO, Manager(s), Supervisor(s) and Business Owner(s) and label Attachment 16.*

V. DISCLAIMER

I hereby affirm under the penalties of perjury that the information given by me in this application is true and complete to the best of my knowledge and belief. I understand that to falsify information is grounds for disapproval of my application and for discharge as a provider should DDA be made aware of information contrary to which has been provided in this application. I authorize DDA to request and receive information from any person, organization or company listed on this application regarding my previous employment, education and qualifications to provide services and support under DDA's Family Support and/or Community Supports Waivers.

Privacy Notice – The information in your application is not routinely shared with other governmental agencies. However, by accepting this notice of privacy, I understand that the Maryland Department of Health's Medicaid Program, auditors, inspectors and other government officials may review it.

Applicant's Signature

______________________________________ _________________

Signature Date

Required Attachments for All Participants:

1. Documentation of any name you or the organization is "doing business as", if applicable, labeled as **Attachment 1;**
2. Verification of the National Provider Identifier in the form of a document generated by the National Plan and Provider (NPPES), if applicable, labeled as **Attachment 2;**
3. Letter or document verifying Medicaid Provider Number if assigned with labeled as **Attachment 3**;
4. Letter from IRS verifying Business Tax ID number labeled as **Attachment 4;**
5. A copy of the Articles of Incorporation, if applicable, labeled as **Attachment 5**;
6. Copies of college degree(s) and resume(s) for all initial individual applicants labeled as **Attachment 6**; (This attachment is not required for individual applicants renewing their applications).
7. Copies verifying relevant licenses, certifications and trainings for all initial individual applicants. Renewal individual applicants should provide updated licenses, certification and training. Documents should be labeled as **Attachment 7**;
8. A copy of the applicant's social security number and Business Owner(s) social security numbers and information labeled as **Attachment 8**;
9. Three professional references, if an initial applicant, labeled as **Attachment 9;**
10. Business/Agency Credentials, Accreditations, or Certifications labeled as **Attachment 10**;
11. Copy of General Commercial Liability Insurance Coverage pages labeled as **Attachment 11;**
12. Copy of Automobile Coverage pages labeled as **Attachment 12;**
13. Other State or Agency license(s) and prior licensing reports issued within the previous 10 years from any in-state or out-of-state regulatory office, including deficiency reports and compliance records (excluding OHCQ deficiency reports for DDA licensed services) labeled as **Attachment 13;**
14. Completed IRS Form 990 for the previous year of business if non-profit or completed Form1120 for business if for profit labeled as **Attachment 14;**
15. Required background checks labeled as **Attachment 15;**
16. Child Protective Clearance(s) labeled as **Attachment 16;**
17. Conditions of Participation; and
18. Application Checklist

Individual applicants can stop here. Business/Agency applicants will continue.

Additional Attachments for Businesses/Agencies:

1. Completed Business/Agency Questionnaire and Information Form;
2. Program Service Plan/Information which includes all services and supports to be rendered and a copy of the DDA approval letter for transition plan for any sites not meeting the Community Settings Rule labeled as **Attachment 17**;
3. Copy of document verifying your worker's insurance compensation vendor, coverage and term dates labeled as **Attachment 18;**
4. Copy of document verifying your unemployment insurance vendor, coverage and term dates and labeled as **Attachment 19.**
5. Quality Assurance Plan/Information labeled as **Attachment 20;**
6. Board of Directors/Officers Form and/or related information labeled as **Attachment 21;**
7. Current and proposed budgets labeled as **Attachment 22;**
8. Required background checks for Administrators, Managers, and Supervisors labeled as **Attachment 23;**
9. Child Protective Clearance(s) if serving children for Administrators, Managers and Supervisors labeled as **Attachment 24;** and
10. Organized Health Care Delivery System Form, if applicable.

Business/Agency Questionnaire and Information Form

This form should be completed in its entirety for initial applications from Businesses/Agencies and those seeking to renew DDA Approval to render services and/or supports or their licenses. Current providers should indicate how information has changed since the previous application and provide current dates as applicable.

I. Program Service Plan

All initial Business/Agency applicants (including those proposing to render non-licensed, non-certified services, must submit a Program Service Plan with this application which meets requirements listed below and label it as Attachment 17. Applicants seeking to renew DDA Approval and/or their license to render services and supports must have a Program Service Plan reviewed by their Governing Body and/or Officer, updated and approved by DDA every three years. If you have not submitted an updated plan to DDA, please include your Program Service Plan with this application and label it as Attachment 17.

A. IS THERE A PROGRAM SERVICE PLAN INCLUDED IN THIS APPLICATION?

☐ yes or ☐ no

If yes, indicate date of approval ________ and submit as Attachment 17.
If no, please explain submitting this information as Attachment 17.

B. PLEASE CHECK IF YOUR PROGRAM SERVICE PLAN INCLUDES THE FOLLOWING REQUIRED COMPONENTS

1. Business/agency's mission statement and values as they relate to participants with developmental disabilities and how they support DDA's mission and values
   ☐ yes or ☐ no
2. Business/agency's vision and long-range goals, and how they will affect the services/supports the business/agency provides to participants with developmental disabilities whom the business/agency proposes to serve this year and in the future
   ☐ yes or ☐ no
3. Describes how the business/agency will support participants with developmental disabilities to participate in integrated community activities
   ☐ yes or ☐ no
4. Describes what should be considered when supporting participants with challenging behaviors, co-occurring illnesses, and significant health needs, as well as the habilitative needs of participants and the applicable services and supports provided or to be provided which address the needs of participants
   ☐ yes or ☐ no
5. Indicates the number of staff employed, the business/agency's organizational structure, and staff's job descriptions with relevant educational and experience requirements
   ☐ yes or ☐ no
6. Includes the critical personnel needed (e.g. Targeted Case Managers, Health Case Management and/or Delegating Nurse(s), Psychologist(s), Psychologist Associate(s), Other Behavioral Support Providers, Executive Director, Manager(s), Supervisor(s), Vocational Staff, CNAS, CMAS, Fiscal Management Services as applicable which demonstrate that the business/agency can sufficiently provide the services and/or supports to participants with developmental disabilities in which DDA approval or the license is sought.
   ☐ yes or ☐ no
   Please include resumes, licenses, certifications, and documents verifying required trainings (including CPR and First Aid) in your Program Service Plan. For a new business/agency, please also submit three professional references for your Executive Director, Program Director, and/or Manager
7. If applying for a license, has your business/agency developed policies and procedures which meet requirements in COMAR 10.22.10?
   ☐ yes ☐ no or ☐ not applicable
   If DDA approves your application, policies and procedures must be submitted to the OHCQ within 30 days of the date of approval of the application.

II. Insurance

A. Do you have worker's compensation insurance coverage?

☐ yes or ☐ no

Submit copy of document verifying your worker's insurance compensation vendor, coverage and term dates and label as Attachment 18.

B. Do you have unemployment insurance coverage?

☐ yes or ☐ no

Submit copy of document verifying your unemployment insurance coverage vendor, coverage and term dates and label as Attachment 19.

III. Quality Assurance and Governance

All initial Business/Agency applicants (including those proposing to render non-licensed, non-certified services) must have a Quality Assurance Plan. Applicants seeking to renew their licenses or DDA Approval to render services and supports must submit a Quality Assurance Plan with signatures and dates which reflect approval and annual review from Governing Body Members, the CEO or an administrator (as applicable), respectively.

A. Is there a quality assurance plan included in this application?

☐ yes or ☐ no

Submit the Quality Assurance Plan as Attachment 20.

B. Please check if the quality assurance plan includes the following required components

1. Methods for ensuring that participants' preferences and choices are honored, and there are personal contacts with participants
   ☐ yes or ☐ no
2. Person-centered plans for participants with measurable outcomes
   ☐ yes or ☐ no
3. Activities involving collection and evaluation of data, analyzing trends, and appropriate interventions (which address incident reporting, evaluating and meeting behavior supports and/or health needs of participants, and use of restrictive interventions)
   ☐ yes or ☐ no
4. Goals and proactive strategies for accomplishing goals for delivery of quality services and supports
   ☐ yes or ☐ no
5. A policy regarding the board of directors which includes board members' qualifications, role, frequency of meetings, minutes, etc.
   ☐ yes ☐ no or ☐ not applicable
   Business/agencies seeking a license must have a board of directors and must complete the governing body/board of directors' form and provide minutes from the previous year. If you are a license applicant and you do not currently have a board of directors, please indicate actions taken and target date for board to be in place. Label information as Attachment 21.
6. Methods which ensure the following (please check or yes or no if all requirements below are met or are not met):
   a. That all employees providing direct services with participants with developmental disabilities have required criminal background checks,
   b. That current and prospective employees convicted of crimes posing a risk to participants with developmental disabilities do not provide direct services and/or are assigned duties which require them to work alone with individuals, and
   c. Current and prospective employees will meet statutory and regulatory requirements in the DDA policy of reportable incidents and investigations, rights of individuals afforded in annotated code of Maryland, Health-General, 7-1002 and required training in COMAR 10.22.02.

   ☐ yes ☐ no
7. For agencies without a governing board, does your quality assurance plan explain how it was developed?
   ☐ yes ☐ no or ☐ not applicable

8. Describe in detail your experience operating a business. If you do not have this experience, please describe how you will obtain this expertise**.** (please skip this question if you an applicant seeking to renew your DDA license and/or DDA approval to render services/supports and check "not applicable") ☐not applicable

IV. Fiscal Management

A. Current and Proposed Budgets- If a DDA license and/or approval is granted to your business/agency, payment for services and supports may not be received for up to 180 days from the date of service initiation. You will incur operating expenses during this period. Initial applicants must submit the business/agency's business plan which includes a proposed budget for the first year of services and supports the business/agency plans to provide and a projected budget for the next year. Business/Agencies renewing a license must submit current and/or proposed budget, two most previous years' budgets and explain any variances. All applicants must also ensure submission of tax documents indicated in Attachment 14.

1. **Are there current and/or proposed budgets included in this application as required?**
   ☐ yes or ☐ no

Submit current and proposed budgets as Attachment 22.

2. **Please check if current and/or proposed budgets include the following required components**
   - **a.** Costs incurred from specified positions and employee salaries, taxes, equipment, insurance, space, transportation/travel, training, supplies, etc.
     ☐ yes or ☐ no
   - **b.** Sources and amounts of start-up funds for initial applicants (Information provided must include verification of income in the form of a current letter (within 30 days of submission of application) from an accredited bank or other financial institution documenting a line of credit, business loan, or availability of funds).
     ☐ yes ☐ no or ☐ not applicable for current providers
   - **c.** All sources and income, and details for any fundraising activities
     ☐ yes or ☐ no

B. Please explain how the business/agency will ensure sound fiscal operations?

C. Does the business/agency have any outstanding debts to or disallowances from DDA, other state and/or federal agencies?

☐ yes or ☐ no

If yes, please explain.

V. ORGANIZED HEALTH CARE DELIVERY SYSTEM

Business/Agencies designated as Organized Health Care Delivery System (OHCDS) may subcontract with Medicaid and Non-Medicaid providers to allow individuals to receive services approved in their Individual Plan in the manner which best suits their needs and results in the more complete fulfillment of their plans. To qualify as an OHCDS, an applicant:

1. Must be licensed to provide one of the following services:
    1. Support services designated by the department
    2. Day Services
    3. Employment Services
    4. Residential Services
    5. Any other services designated by the department;
2. Be an enrolled Medicaid provider and render at least one Medicaid Service directly; and
3. Meet other requirements in COMAR 10.22.20

ARE YOU APPLYING TO BE DESIGNATED AS AN ORGANIZED HEALTH CARE DELIVERY SYSTEM?

☐ yes or ☐ no

If yes, please complete the Organized Health Care Delivery System Form and submit it with your application.

______________________________ ______________________________

Signature and Title Date

Additional Required Documentation to be submitted from Applicants Seeking a Residential Child Care Facility License:

V.B.1. Copies of the Program Administrator's required degrees, licenses, resume, and letter of appointment by the Board (COMAR 14.31.06.06(A)(2))

V.B.2. Description of facility, including diagram (COMAR 14.31.06.07)

V.B.3. Menu plan and Nutritional Consultant's report (COMAR 14.31.06.10.B.(2) & (9) (b))

V.B.4. Letters of support/documentation of need

V.B.5. Program service plan which addresses:

- **A.** Philosophy of provision of services
- **B.** Capacity of facility
- **C.** Sex and age range of participants
- **D.** Admission criteria
- **E.** Client rights and grievance procedures
- **F.** Individual service plans
- **G.** Treatment Modalities
- **H.** Family Involvement
- **I.** Daily routines
- **J.** Life needs
- **K.** Religious activities
- **L.** Allowances/money
- **M.** Clothing/personal belongings
- **N.** Personal hygiene standards
- **O.** Sleep
- **Q.** Life skills
- **R.** Training
- **S.** Somatic health care
- **T.** Child abuse and neglect
- **U.** Discipline
- **V**. Absent without leave (AWOL)
- **W.** Discharge

V.B.6. Written policies and procedures as per COMAR reference noted in parenthesis, including:

A. Organization and administration (14.31.05.04);
B. Governance (14.31.06.04);
C. Personnel administration (14.31.06.05);
D. Employee duties and qualifications (14.31.06.06);
E. Emergency and General Safety, (14.31.06.08);
F. General program requirements (14.31.06.09);
G. Basic life needs (14.31.06.10);
H. Children's rights (14.31.06.11);
I. Children's services (14.31.06.12);
J. Health care (14.31.06.13);
K. Child abuse and neglect (14.31.06.14);
L. Behavioral Interventions, Strategies, and Supports (14.31.06.15);
M. Absence without leave (14.31.06.16);
N. Admission, individual service plan, behavior plan, and discharge (14.31.06.17);
O. Reports and records (14.31.06.18); and
P. Additional as required for licensure of specialized programs (14.31.07).

V.B.7. Physical plant inspection, including:

Q. Report of Public Health Authority COMAR 14.31.06.07(A)(4)(a); and

GOVERNING BODY -BOARD OF DIRECTORS/OFFICERS FORM

All applicants seeking a license must have a governing body that perform functions (board of directors) and meet requirements in COMAR 10.22.02.08

Name of Governing Board Member	Governing Board Member Social Security Number	Date Appointed	Member resides within 100 Miles? (Indicate Yes or No)	Member is a Maryland Resident? (Indicate Yes or No)	Indicate Relationship (i.e. Participant, Parent of Participant, Individual with Experience in Field with DD, etc.)