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| **Agency Demographics**  **Organization’s Legal Entity Name:** | | |  | | | | | | | | | | | |
| **Address: Street 1:** | |  | | | | | | | | | | | | |
| **Street 2:** | |  | | | | | | | | | | | | |
| **City:** | |  | | | | | | **State:** | |  | | **Zip:** | **-** | |
| **Phone Number:** | | (   )     - | | |  | | | | | | | | | |
| **MPI Number:** | |  | | | | **FEIN:** |  | | | |  | | | |
|  | | **ODP Waivers Currently Serving:** | | **Adult Autism Waiver**  **ID/A Waivers SCO (P/FDS, Consolidated, Community Living, Base Services)**  **ID/A Waivers Provider (P/FDS, Consolidated, Community Living, Base Services)** | | | | |
| **Please indicate if your agency is qualified as an Organized Healthcare Delivery System (OHCDS) Provider for the any of the services listed:**  **Transportation (55/267)**  **Assistive Technology (55/250)**  **Community Transition Services (55/551)**  **Home/Vehicle Modifications (55/543)**  **Region where the SCO’s main office is located:** | | | | | | | | | | | | | | |
| **Central**  **Northeast**  **Southeast**  **West** | | | | | | | | | | | | | |
| County(s) where the SCO currently provides Supports Coordination services: | | | | | | | | | | | | | | |
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| **Name of contact person for this form:** |  |
| **Email address for the contact person:** |  |

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| **Assurances and Attestations** | | | | |
| 1. The organization agrees to sign the ODP Provider Agreement for Participation in Pennsylvania’s Consolidated, Community Living, P/FDS, and Adult Autism Waivers (“Provider Agreement”).   **A signed Provider Agreement constitutes a commitment to comply with all federal waiver requirements, as well as any other applicable ODP regulations and bulletins issued by the Department of Human Services.** | | | | Yes  No |
| 1. The organization agrees to comply with all federal, state, and local standards applicable to the provision of supports coordination services. | | | | Yes  No |
| 1. The organization agrees to comply with all applicable requirements for operating an organization in Pennsylvania (please choose agency type: 2. Not-for-profit 3. For-Profit 4. Governmental | | | | Yes  No |
| 1. The organization agrees to carry adequate insurance to satisfy the requirements applicable to Supports coordination services, as stipulated in the Adult Autism Waiver as required by PA State law    1. Workers’ Compensation Insurance    2. Commercial General Liability Insurance | | | | Yes  No |
| 1. The organization attests that it does not provide direct Adult Autism Waiver services, other than supports coordination services. | | | | Yes  No |
| 1. The organization is in compliance with all applicable *Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements (P.L. 104-191) (45 CFR Parts 160 and 164).* | | | | Yes  No |
| 1. The organization assures that it has a process for using The Home and Community Services Information System (HCSIS) to document the performance of supports coordination functions and activities. | | | | Yes  No |
| 1. The organization assures that it will enter and maintain its current provider-related information in HCSIS and PROMIS*e*TM. | | | | Yes  No |
| 1. The organization assures that it will have a written procedure for the reconciliation of claims, the management of denied claims and the rebilling of denied claims. | | | | Yes  No |
| 1. The organization assures that it will accept its approved supports coordination reimbursement rate as payment in full and will not charge the individual or any other public funding source for waiver eligible supports coordination services. | | | | Yes  No |
| 1. The organization assures that it has a utilization process through HCSIS/PROMISeTM for reconciliation of claims and rebilling. | | | | Yes  No |
| 1. The organization assures that it will cooperate with and assist, as needed, ODP and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting Medicaid fraud and abuse. | | | | Yes  No |
| 1. The organization assures that it will comply with all applicable ODP policies and procedures. | | | | Yes  No |
| 1. The organization assures that it will provide immediate written notification to ODP of any non-compliance or failure to meet any of these qualification criteria. | | | | Yes  No |
| 1. The organization assures that it will participate in transition planning in the event that it terminates its Provider Agreement or is terminated by ODP as a provider of supports coordination services. | | | | Yes  No |
| 1. The organization assures that it will participate in supports coordination training conducted or required   by ODP. | | | | Yes  No |
| 1. The organization attests that it will use ODP’s new SC Orientation Curriculum that includes the following but not limited to: 2. Person-centered practices, community integration, individual choice and assisting individuals to develop and maintaining relationships. 3. The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with 35 P.S. § 10225.701-708, 6 Pa. Code Chapter 15, 23 Pa. C.S. §§ 6301-6385, Chapter 3490, 35 P.S. §§ 10210.101-704 and applicable adult protective services regulations 4. Individual Rights 5. Recognizing and reporting incidents. 6. Job-related knowledge and skills | | | | Yes  No |
| 1. The organization assures that it will provide additional training to comply with the ODP required annual training hours for SCs and SC Supervisors.   **Verification of this assurance requires the establishment and maintenance of training records, training curricula, attendance records and orientation materials.** | | | | Yes  No |
| 1. The organization assures that it will comply with the minimum monitoring requirements for waiver participant monitoring at the frequency outlined in the approved Adult Autism Waiver. | | | | Yes  No |
| 1. The organization assures that it will comply with the standards related to supports coordination organization qualification. | | | | Yes  No |
| 1. The organization assures that it will demonstrate compliance with ODP standards through completion of a self-assessment and validation of required documentation, policies and procedures. | | | | Yes  No |
| 1. The organization assures that it will cooperate in the development of corrective action plans that   result from any monitoring conducted by ODP, where such plans call for action  on the part of the SCO. | | | | Yes  No |
| 1. The organization assures that it will comply fully with ODP’s Incident Management Policy. | | | | Yes  No |
| 1. The organization attests that it has a quality management plan consistent with the approved ODP waiver(s). | | | | Yes  No |
| 1. The organization attests that it has sufficient SCO personnel to carry out all functions to operate, with each SC carrying a caseload of no more than 35 individuals and ensuring that SCs are not acting as their own supervisors. | | | | Yes  No |
| 1. The organization attests that all Supports Coordinators with a caseload meet the following minimum requirements: 2. Have a criminal history check with no offenses that preclude employment under 35 P. S. §10225.101 et seq. and 6 Pa. Code Chapter 15. 3. Have a valid driver’s license if the operation of a vehicle is necessary to provide Supports Coordination services. | | | | Yes  No |
| 1. The organization attests that all Supports Coordinators meet the following minimum education and experience requirements. 2. Have at least a Bachelor’s degree in Education, Psychology, Social Work, or other related social sciences and 3. Have either 1) at least three years’ experience providing case management for people with disabilities or 2) at least three years’ experience working with people with autism spectrum disorders. | | | | Yes  No |
| 1. The organization attests that it complies with regulations set forth in *55 Pa. Code Chapter 6100, Office of Developmental Programs Home and Community-Based Services.* | | | | Yes  No |
| **The statements made herein are subject to the penalties of *18 Pa. C.S. §4904* relating to unsworn falsification to authorities.**   |  |  |  | | --- | --- | --- | | **Name of Executive Director:**  or person who serves in that capacity |  |  | |  | | **Title:** |  |  | | **Signature:** |  |  | | **Date:** |  |  | | | | | |
| **ODP Verification** | | | | |
| Name & Title of ODP Representative:  Date:  New SCO: Must requalify by the end of the following fiscal year after enrolling first site.  Existing SCO: Must requalify on a three-year cycle based upon the last digit of the SCO’s MPI number.    OHCDS  OHCDS: Must requalify on a three-year cycle based upon the last digit of the SCO’s MPI number | | | |  |