Department of Health
Developmental Disabilities Supports Division

Developmental Disabilities (DD) Waiver Provider Information Sheet

(Form must be filled out completely)
PLEASE PRINT CLEARLY

Date: _____ **New Applicant** _____ **Renewing Applicant** _____

State Bureau of Revenue CRS# _____ **Medicaid Billing #**_____

Business Name (dba) _____

Contact Person _____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

Physical Address _____

City _____ **State** _____ **Zip Code** _____

Phone # _____ **Fax #** _____ **Cell #** _____

E-mail Address _____ **Toll Free #** _____

Please answer the following questions regarding your organization:
1.) Does any other organization (including those who currently or previously provided service under the DDSD Medicaid Waiver program) control or influence your agency? Yes _____ *(or)* **No** _____
(If "YES" please provide name(s) and contact information below if necessary submit a separate sheet)

Contact _____ **Phone #** _____ **Email** _____

2.) Does your agency control or influence any other organization (including those who currently or previously provided service under the DDSD Medicaid Waiver program)? Yes _____ *(or)* **No** _____
(If "YES" please provide name(s) and contact information below if necessary submit a separate sheet)
Contact _____ **Phone #** _____ **Email** _____

1. Name and address of each person with an ownership or controlling interest in the entity.

Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**

2. Name of any person, agent, managing employee or any other person who has ownership or controlling interest in the entity who has been convicted of a criminal offense or assessed a civil monetary penalty related to that person's involvement in any program under Medicaid, Medicare, other federal program or other state Medicaid programs.

Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**

Signature of Authorized Representative:	**Title:**

Revised 4.1.2019

COUNTY AND SERVICE REQUEST FORM
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
DEVELOPMENTAL DISABILITIES (DD) WAIVER

PROVIDER NAME: **DATE:**

DD WAIVER CASE MANAGEMENT

CASE MANAGEMENT AGENCIES MUST PROVIDE SERVICES TO ALL COUNTIES IN AN ENTIRE REGION. (SEE ENCLOSED MAP)

- ☐ METRO
- ☐ NORTHEAST
- ☐ NORTHWEST
- ☐ SOUTHEAST
- ☐ SOUTHWEST

DD WAIVER CLINICAL SERVICES

- ☐ ADULT NURSING
- ☐ ASSISTIVE TECHNOLOGY
- ☐ NUTRITIONAL COUNSELING
- ☐ OCCUPATIONAL THERAPY
- ☐ PERSONAL SUPPORT TECHNOLOGY
- ☐ PHYSICAL THERAPY
- ☐ SPEECH THERAPY
- ☐ SUPPLEMENTAL DENTAL

DD WAIVER COMMUNITY INCLUSION SERVICES

- ☐ CUSTOMIZED COMMUNITY SUPPORTS-GROUP
- ☐ CUSTOMIZED COMMUNITY SUPPORTS-INDIVIDUAL
- ☐ COMMUNITY INTEGRATED EMPLOYMENT-INDIVIDUAL
- ☐ COMMUNITY INTEGRATED EMPLOYMENT-GROUP

DD WAIVER BEHAVIORAL SUPPORTS SERVICES

- ☐ BEHAVIORAL SUPPORT CONSULTATION
- ☐ CRISIS SUPPORTS
- ☐ PRELIMINARY RISK SCREENING
- ☐ SOCIALIZATION AND SEXUALITY

DD WAIVER LIVING SUPPORTS

- ☐ FAMILY LIVING / FL-ADULT NURSING
- ☐ INTENSIVE MEDICAL LIVING
- ☐ SUPPORTED LIVING

OTHER DD WAIVER SUPPORTS SERVICES

- ☐ CUSTOMIZED IN-HOME SUPPORTS
- ☐ ENVIRONMENTAL MODIFICATION
- ☐ INDEPENDENT LIVING TRANSITION
- ☐ NON-MEDICAL TRANSPORTATION
- ☐ RESPITE

PLEASE SUBMIT A SEPARATE FORM IF YOU ARE PROVIDING MULTIPLE SERVICES IN MULTIPLE REGIONS.
PLEASE CHECK THE COUNTIES YOU ARE APPLYING TO PROVIDE SERVICES IN

METRO	☐ BERNALILLO	☐ SANDOVAL	☐ TORRANCE	☐ VALENCIA		
NORTHEAST	☐ COLFAX	☐ HARDING	☐ LOS ALAMOS	☐ MORA	☐ RIO ARRIBA	☐ SAN MIGUEL
	☐ SANTA FE	☐ TAOS	☐ UNION			
NORTHWEST	☐ CIBOLA	☐ MCKINLEY	☐ SAN JUAN			
SOUTHEAST	☐ CHAVES	☐ CURRY	☐ DE BACA	☐ EDDY	☐ GUADALUPE	☐ LEA
	☐ LINCOLN	☐ QUAY	☐ ROOSEVELT			
SOUTHWEST	☐ CATRON	☐ DONA ANA	☐ GRANT	☐ HIDALGO	☐ LUNA	☐ OTERO
	☐ SIERRA	☐ SOCORRO				

Revised 4.1.2019

Department of Health
Developmental Disabilities Supports Division

Medically Fragile (MF) Waiver Provider Information Sheet

(Form must be filled out completely)
PLEASE PRINT CLEARLY

Date: _____ **New Applicant** _____ **Renewing Applicant** _____

State Bureau of Revenue CRS# _____ **Medicaid Billing #**_____

Business Name (dba) _____

Contact Person _____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

Physical Address _____

City _____ **State** _____ **Zip Code** _____

Phone # _____ **Fax #** _____ **Cell #** _____

E-mail Address _____ **Toll Free #** _____

Please answer the following questions regarding your organization:
1.) Does any other organization (including those who currently or previously provided service under the DDSD Medicaid Waiver program) control or influence your agency? Yes _____ *(or)* **No** _____
(If "YES" please provide name(s) and contact information below if necessary submit a separate sheet)

Contact _____ **Phone #** _____ **Email** _____

2.) Does your agency control or influence any other organization (including those who currently or previously provided service under the DDSD Medicaid Waiver program)? Yes _____ *(or)* **No** _____
(If "YES" please provide name(s) and contact information below if necessary submit a separate sheet)

Contact _____ **Phone #** _____ **Email** _____

1. Name and address of each person with an ownership or controlling interest in the entity.

Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**

2. Name of any person, agent, managing employee or any other person who has ownership or controlling interest in the entity who has been convicted of a criminal offense or assessed a civil monetary penalty related to that person's involvement in any program under Medicaid, Medicare, other federal program or other state Medicaid programs.

Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**

Signature of Authorized Representative:	**Title:**

Revised 4.1.2019

SERVICE AND COUNTY REQUEST FORM
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
MEDICALLY FRAGILE (MF) WAIVER

PROVIDER NAME **DATE**

CASE MANAGEMENT

CASE MANAGEMENT AGENCIES MUST PROVIDE SERVICES TO ALL COUNTIES IN AN ENTIRE REGION.

SEE ENCLOSED MAP

- ☐ METRO
- ☐ NORTHEAST
- ☐ NORTHWEST
- ☐ SOUTHEAST
- ☐ SOUTHWEST

CLINICAL SERVICES

- ☐ BEHAVIOR SUPPORT CONSULTATION
- ☐ ENVIRONMENTAL MODIFICATION
- ☐ HOME HEALTH AIDE
- ☐ IN-HOME RESPITE
- ☐ NUTRITIONAL COUNSELING
- ☐ OCCUPATIONAL THERAPY
- ☐ PHYSICAL THERAPY
- ☐ PRIVATE DUTY NURSING
- ☐ SPECIALIZED MEDICAL EQUIPMENT & SUPPLIES
- ☐ SPECIALIZED RESPITE HOME
- ☐ SPEECH THERAPY

PLEASE SUBMIT A SEPARATE FORM IF YOU ARE PROVIDING MULTIPLE SERVICES IN MULTIPLE REGIONS.
PLEASE CHECK THE COUNTIES YOU ARE APPLYING TO PROVIDE SERVICES IN.

METRO	☐ BERNALILLO	☐ SANDOVAL	☐ TORRANCE	☐ VALENCIA		
NORTHEAST	☐ COLFAX	☐ HARDING	☐ LOS ALAMOS	☐ MORA	☐ RIO ARRIBA	☐ SAN MIGUEL
	☐ SANTA FE	☐ TAOS	☐ UNION			
NORTHWEST	☐ CIBOLA	☐ MCKINLEY	☐ SAN JUAN			
SOUTHEAST	☐ CHAVES	☐ CURRY	☐ DE BACA	☐ EDDY	☐ GUADALUPE	☐ LEA
	☐ LINCOLN	☐ QUAY	☐ ROOSEVELT			
SOUTHWEST	☐ CATRON	☐ DONA ANA	☐ GRANT	☐ HIDALGO	☐ LUNA	☐ OTERO
	☐ SIERRA	☐ SOCORRO				

Department of Health
Developmental Disabilities Supports Division

Supports Waiver Provider Information Sheet

(Form must be filled out completely)
PLEASE PRINT CLEARLY

Date: _____ **New Applicant** _____ **Renewing Applicant** _____

State Bureau of Revenue CRS# _____ **Medicaid Billing #**_____

Business Name (dba) _____

Contact Person _____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

Physical Address _____

City _____ **State** _____ **Zip Code** _____

Phone # _____ **Fax #** _____ **Cell #** _____

E-mail Address _____ **Toll Free #** _____

Please answer the following questions regarding your organization:
1.) Does any other organization (including those who currently or previously provided service under the DDSD Medicaid Waiver program) control or influence your agency? Yes _____ *(or)* **No** _____
(If "YES" please provide name(s) and contact information below if necessary submit a separate sheet)

Contact _____ **Phone #** _____ **Email** _____

2.) Does your agency control or influence any other organization (including those who currently or previously provided service under the DDSD Medicaid Waiver program)? Yes _____ *(or)* **No** _____
(If "YES" please provide name(s) and contact information below if necessary submit a separate sheet)
Contact _____ **Phone #** _____ **Email** _____

1. Name and address of each person with an ownership or controlling interest in the entity.

Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**

2. Name of any person, agent, managing employee or any other person who has ownership or controlling interest in the entity who has been convicted of a criminal offense or assessed a civil monetary penalty related to that person's involvement in any program under Medicaid, Medicare, other federal program or other state Medicaid programs.

Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**
Name:		
Address:	**Telephone Number:**	**Relationship:**

Signature of Authorized Representative:	**Title:**

Revised 4.1.2019

COUNTY AND SERVICE REQUEST FORM
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
SUPPORTS WAIVER

PROVIDER NAME: **DATE:**

COMMUNITY SUPPORTS COORDINATOR

COMMUNITY SUPPORTS COORDINATORS MUST PROVIDE SERVICES TO ALL COUNTIES IN AN ENTIRE REGION (SEE ENCLOSED MAP)

- ☐ METRO
- ☐ NORTHEAST
- ☐ NORTHWEST
- ☐ SOUTHEAST
- ☐ SOUTHWEST

- ☐ CUSTOMIZED COMMUNITY SUPPORTS-GROUP
- ☐ CUSTOMIZED COMMUNITY SUUPORTS-INDIVIDUAL
- ☐ SUPPORTED EMPLOYMENT

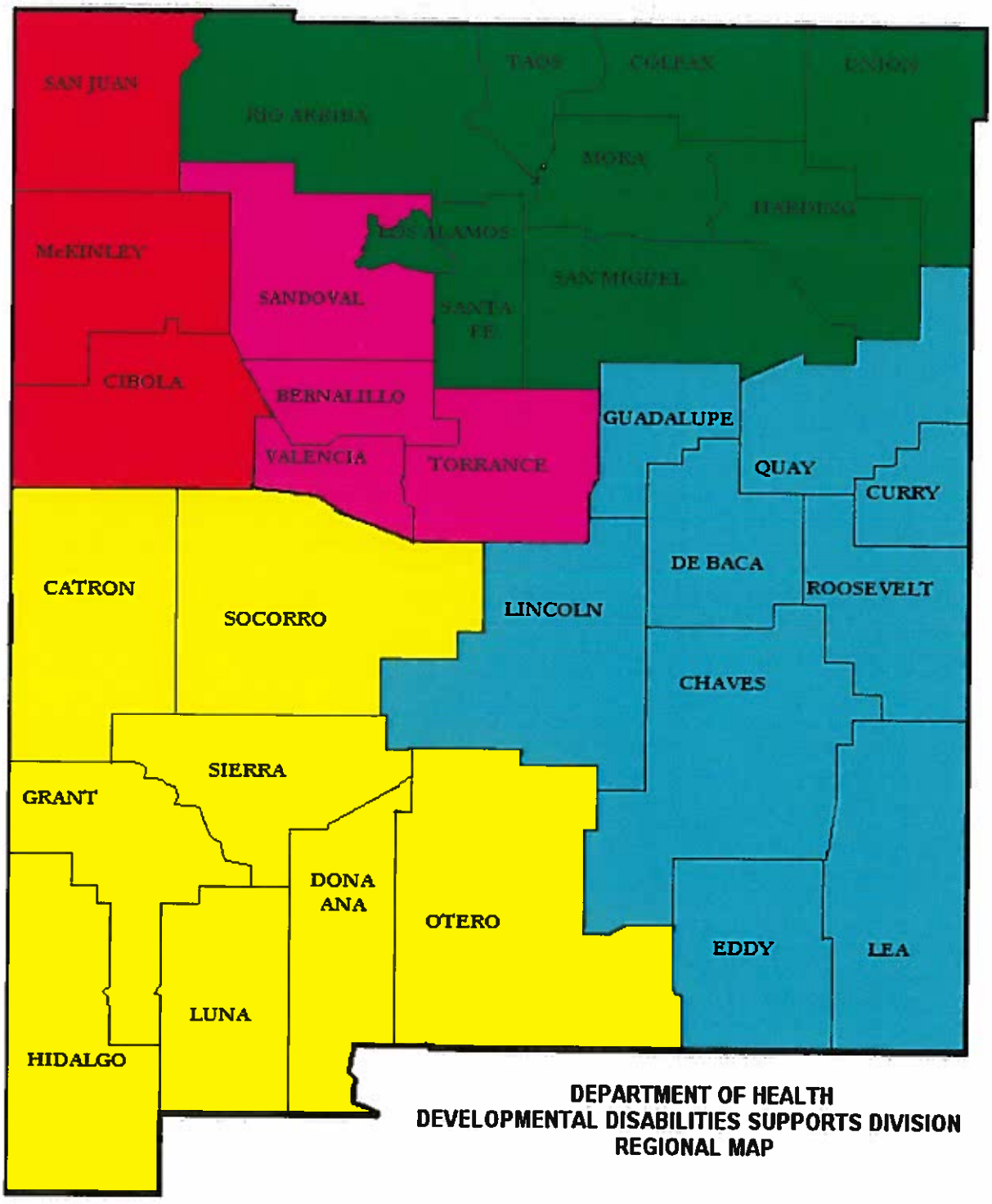
- ☐ ASSISTIVE TECHNOLOGY
- ☐ BEHAVIOR SUPPORT CONSULTATION
- ☐ PERSONAL CARE
- ☐ RESPITE

- ☐ ENVIRONMENTAL MODIFICATION
- ☐ NON-MEDICAL TRANSPORTATION
- ☐ VEHICLE MODIFICATION

PLEASE SUBMIT A SEPARATE FORM IF YOU ARE PROVIDING MULTIPLE SERVICES IN MULTIPLE REGIONS.
PLEASE CHECK THE COUNTIES YOU ARE APPLYING TO PROVIDE SERVICES IN.

METRO	☐ BERNALILLO	☐ SANDOVAL	☐ TORRANCE	☐ VALENCIA		
NORTHEAST	☐ COLFAX	☐ HARDING	☐ LOS ALAMOS	☐ MORA	☐ RIO ARRIBA	☐ SAN MIGUEL
	☐ SANTA FE	☐ TAOS	☐ UNION			
NORTHWEST	☐ CIBOLA	☐ MCKINLEY	☐ SAN JUAN			
SOUTHEAST	☐ CHAVES	☐ CURRY	☐ DE BACA	☐ EDDY	☐ GUADALUPE	☐ LEA
	☐ LINCOLN	☐ QUAY	☐ ROOSEVELT			
SOUTHWEST	☐ CATRON	☐ DONA ANA	☐ GRANT	☐ HIDALGO	☐ LUNA	☐ OTERO
	☐ SIERRA	☐ SOCORRO				

Revised 3.2020



DEPARTMENT OF HEALTH
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
REGIONAL MAP

- NORTHWEST REGION
- NORTHEAST REGION
- SOUTHWEST REGION
- SOUTHEAST REGION
- METRO REGION

Department of Health
Developmental Disabilities Supports Division
Statement of Assurances

Failure to comply with this Statement of Assurances may result in DDSD sanctions, up to and including a reduction in the term and/or termination of the Provider Agreement.

This form must be completed and signed by the applicant. If any portion does not apply to your agency, please mark non-applicable.

	INITIAL	DATE	N/A
Any individual who is an employee or subcontractor of an entity that is compensated for providing waiver services to an individual, must not provide services as guardian or Power of Attorney for that individual, except when related by affinity or consanguinity.			
Similarity, a person who is an owner, operator or employee of a provider agency, or a subcontractor that is compensated to provide waiver services to a given individual must not be designated under a Power of Attorney to make healthcare decisions for that same individual, unless the owner, operator or employee is related to the individual by blood, marriage or adoption. *See* NMSA 1978, § 24-7A-2(B) (Uniform Healthcare Decisions Act).			
A case management or Community Supports Coordinator provider agency may not be a provider agency for any other waiver service. A case management or Community Supports Consultant provider agency may not provide guardianship services to an individual receiving case management or Community Supports Coordinator services from that same agency. Case managers or Community Supports Coordinators are not permitted to serve on the board of a provider agency.			
Provider agencies will follow the Center for Medicare and Medicaid Services (CMS) Final Rule requirements. https://www.medicaid.gov/medicaid/home-community-based-services/index.html			
Provider agencies will learn and use designated electronic systems as required for documentation, reporting and billing (i.e. Therap components, Conduent online portals, other online portals, etc.)			
Provision of data that validates service provision as requested in by the State for audits, validation of rates of reimbursement during periodic rate reviews/rate studies or other quality assurance activities.			
Provider agencies will document provision of services according to Medicaid billing requirements.			

Provider agencies will provide Adult Nursing Services and comply with the DD Waiver Service Standard requirements for this service, as applicable.			
Provider will maintain all individual's files for up to six (6) years after the termination, Expiration of Provider Agreement or when an individual chooses to transition to another agency. Jackson Class Member files will be maintained permanently.			
Provider agencies must submit liability and bond insurance to the Provider Enrollment Unit (PEU) annually.			
Provider will submit a current list of each Board Member's name, home address, phone number and email address to the PEU annually, if applicable.			
Provider agencies must notify the PEU if there is a change in licensee or subcontractor status with the provider agency.			
MF Waiver providers will maintain current certificates for licensed health facilities.			

IMPORTANT:

Failure to comply with the DDSD Statement of Assurances may result in DDSD sanctions, up to and including a reduction in the term and/or termination of the Provider Agreement.

_____ _____

Provider Signature and Title

PEU NEW APPLICATION CHECKLIST

Provider Name: _____ Date Received: _____

Reviewer: _____ Date Reviewed: _____

REQUIRED FORMS

____ DDSD Provider Information Form ____ DD ____ MF ____SW

____ Scope of Service Form(s) ____ DD ____ MF ____SW

____ DDSD Statement of Assurances Form

____ Proof of registration with the New Mexico Department of Taxation and Revenue (CRS#)

____ Articles of Incorporation / Board Members ____

____ Proof of Professional Liability Insurance: Naming Department of Health ____

____ Proof of Surety or Fidelity Bond: Naming Department of Health ____

ACCREDITATION

____ New Agency (Accreditation: 18 months to obtain)

____ Exempt (BSC/EM/RN/NC/OT/PT/SLP)

FINANCIAL

____Business Plan ____ Annual Tax Return ____Profit and Loss Statement ____Financial Audit prepared by Accountant ____ Other: _____

PROGRAM _____ DD_____MF _____SW

____ General Program Description ____ Waiver Agency Authoritative Documents Per Service Type

____ Additional Program Descriptions (DDW)

PROFESSIONAL LICENSURE

____ Current Professional Licensure/Certification (BSC/CM/EM/RN/NC/OT/PT/SLP)

____ Living Supports Providers must have RN and NC