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

SERVICE AND COUNTY 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

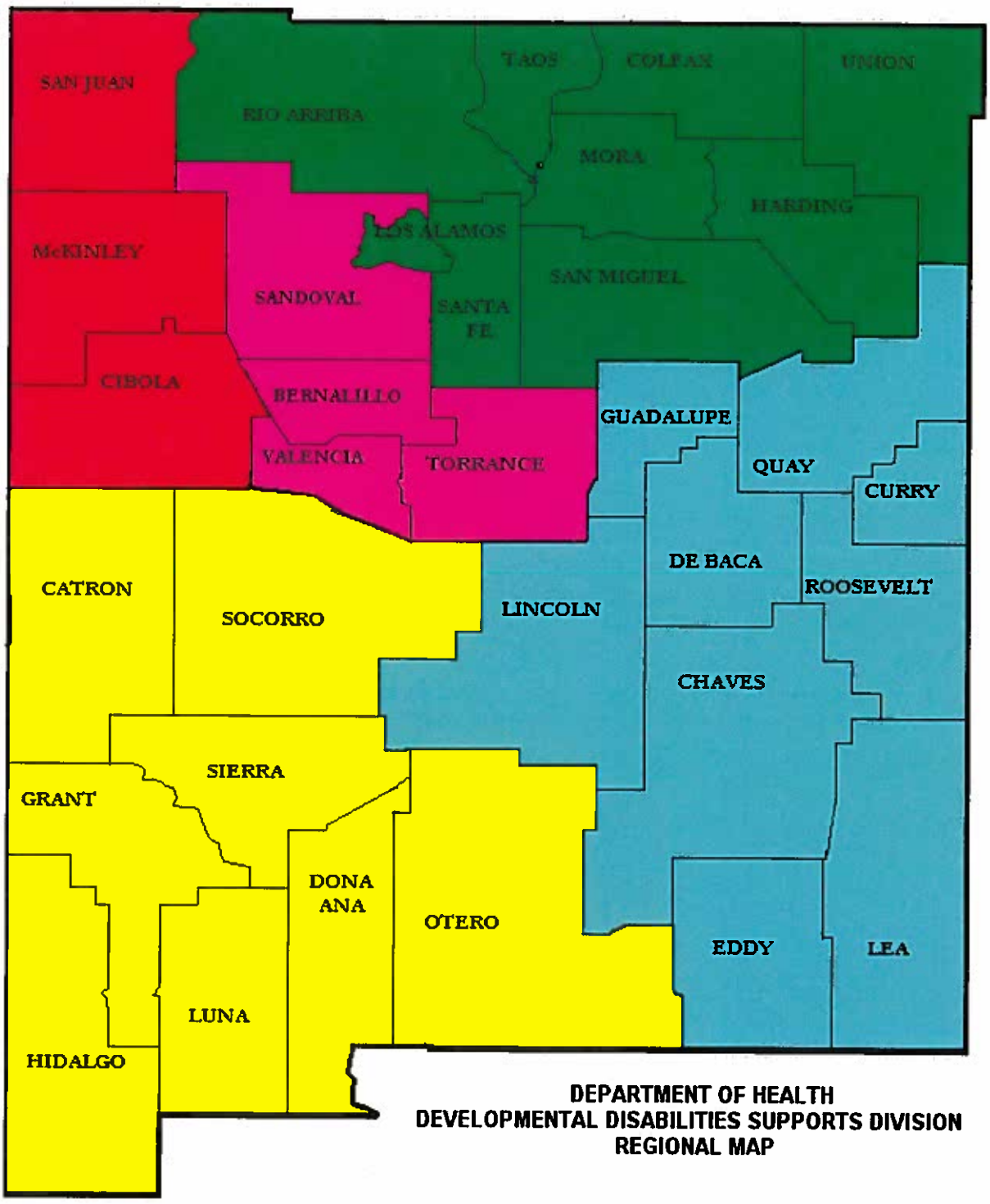
CLINICAL SERVICES

- ☐ BEHAVIORAL 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				

Revised 8.1.2019



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
Provider agencies will use designated electronic systems as required for documentation, reporting and billing (i.e. Therap components)			
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 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 transitions 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 **Date**

Department of Health
Developmental Disabilities Supports Division
Renewing Provider Agency Status Sheet

1. What was the date of your agency's last Quality Management Bureau (QMB) audit? (Applicable services only) _____

2. What was your agency's last QMB audit rating and what were the major issues?

_____
_____
_____

3. If a Plan of Correction was issued, what is the status of the plan? If not closed, please explain why.

_____
_____
_____

4. Has your agency been referred to the Internal Review Committee (IRC)? Yes or No
If so, when and why?

_____
_____
_____

5. Has your agency ever been placed on a State Imposed Moratorium? Yes or No
If so, when and why?

_____
_____
_____

6. Has the Regional Office placed your agency on a Performance Improvement Plan? Yes or No If so, when and why?

_____
_____
_____

7. How many individuals does your agency serve in each service, in each region you are approved to provide services in? (You may attach a separate sheet if needed)

_____
_____
_____

RENEWAL APPLICATION CHECKLIST

REQUIRED FORMS

____ DDSD Provider Information Form ___ DD ___ MF

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

____ Provider Agency Current Status Sheet

____ 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

____ Current Providers - **Expires** _____ ____ Exemption Requested

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

FINANCIAL

____ Current Annual Tax Return ____Current Profit and Loss Statement

____ Current Financial Audit prepared by an Accountant

PROGRAM ___ DD ___ MF

____ Program Descriptions Per Service Type ____ Additional Questions per Service Type

____ Quality Assurance/Quality Improvement (QA/QI) Plan

PROFESSIONAL LICENSURE

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

____ Living Supports Providers must have RN and NC