

Ohio Department of Medicaid  
**OHIO HOME CHOICE DEMONSTRATION PROGRAM**  
**PROVIDER ENROLLMENT APPLICATION/TIME LIMITED AGREEMENT**

**Submit completed signed application/agreement with required attachments to**

HOME Choice Operations Unit  
P.O. Box 182709, 5<sup>th</sup> Floor  
Columbus, Ohio 43218-2709

**Provider Types** (Check ALL that apply)

Agency Providers	Non-Agency Providers
<input type="checkbox"/> HOME Choice Agency Nursing <input type="checkbox"/> HOME Choice Agency Independent Living Skills Training <input type="checkbox"/> HOME Choice Agency Community Support Coach <input type="checkbox"/> HOME Choice Agency Social Work/Counseling Services <input type="checkbox"/> HOME Choice Agency Nutritional Consultation Services <input type="checkbox"/> HOME Choice Agency Communication Aids <input type="checkbox"/> HOME Choice Agency Service Animals <input type="checkbox"/> HOME Choice In-Home Respite Services <input type="checkbox"/> HOME Choice Out-of-Home Respite Services <input type="checkbox"/> HOME Choice Camp Respite Services	<input type="checkbox"/> HOME Choice Non-Agency RN Nursing <input type="checkbox"/> HOME Choice Non-Agency LPN Nursing <input type="checkbox"/> HOME Choice Non-Agency Community Support Coach <input type="checkbox"/> HOME Choice Non-Agency Social Work/Counseling Services <input type="checkbox"/> HOME Choice Non-Agency Nutritional Consultation Services <input type="checkbox"/> HOME Choice In-Home Respite Services

**Provider Identification** (Please print or type entries)

<b>Individual Name (First, Middle Initial, and Last) or Agency Name</b>			
Social Security or EIN Number *	Current or previous Medicaid Number(s) (if applicable)		
Current NPI Number**	License Number ***	License Expiration Date (mm/dd/yyyy)	

\*You must attach a completed and signed W-9 form. Do not use GROUP tax ID number.  
\*\*You must attach a copy of the notice from the NPI Enumerator to verify the NPI Number.  
\*\*\*You must attach a copy of your current state board license.

**Service Location of Practice/Business** (Please print or type entries)

*Non-agency providers may use their home address*

Name/ Building Name/ or Department/ or In care of			
Physical Address (Number, Street, Avenue or Route) (P.O. and Drop Boxes are not acceptable)			Suite Number
City	County	State	Zip Code (Zip +4, if known)
Telephone Number	Cell Phone Number	Email Address	

**"Pay to" Address** (Name & Address to which payment is to be mailed)

*Leave blank if address is the same as "Service Location of Practice/Business"*

Name			
Address			Suite Number
City	State		Zip Code (Zip +4, if known)

**Mailing/Correspondence Address** (Name & Address to which all other material is to be mailed)

*Leave blank if address is the same as "Service Location of Practice/Business"*

Name			
Address			Suite Number
City	County	State	Zip Code (Zip +4, if known)



The HOME Choice Provider may provide the service(s) selected on page one in multiple counties. Please select all the counties in which you agree to provide the selected service(s). For each county selected, you agree to serve all geographic areas therein.

- |                                     |                                    |                                     |                                     |
|-------------------------------------|------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> ADAMS      | <input type="checkbox"/> FAIRFIELD | <input type="checkbox"/> LICKING    | <input type="checkbox"/> PORTAGE    |
| <input type="checkbox"/> ALLEN      | <input type="checkbox"/> FAYETTE   | <input type="checkbox"/> LOGAN      | <input type="checkbox"/> PREBLE     |
| <input type="checkbox"/> ASHLAND    | <input type="checkbox"/> FRANKLIN  | <input type="checkbox"/> LORAIN     | <input type="checkbox"/> PUTNAM     |
| <input type="checkbox"/> ASHTABULA  | <input type="checkbox"/> FULTON    | <input type="checkbox"/> LUCAS      | <input type="checkbox"/> RICHLAND   |
| <input type="checkbox"/> ATHENS     | <input type="checkbox"/> GALLIA    | <input type="checkbox"/> MADISON    | <input type="checkbox"/> ROSS       |
| <input type="checkbox"/> AUGLAIZE   | <input type="checkbox"/> GEAUGA    | <input type="checkbox"/> MAHONING   | <input type="checkbox"/> SANDUSKY   |
| <input type="checkbox"/> BELMONT    | <input type="checkbox"/> GREENE    | <input type="checkbox"/> MARION     | <input type="checkbox"/> SCIOTO     |
| <input type="checkbox"/> BROWN      | <input type="checkbox"/> GUERNSEY  | <input type="checkbox"/> MEDINA     | <input type="checkbox"/> SENECA     |
| <input type="checkbox"/> BUTLER     | <input type="checkbox"/> HAMILTON  | <input type="checkbox"/> MEIGS      | <input type="checkbox"/> SHELBY     |
| <input type="checkbox"/> CARROLL    | <input type="checkbox"/> HANCOCK   | <input type="checkbox"/> MERCER     | <input type="checkbox"/> STARK      |
| <input type="checkbox"/> CHAMPAIGN  | <input type="checkbox"/> HARDIN    | <input type="checkbox"/> MIAMI      | <input type="checkbox"/> SUMMIT     |
| <input type="checkbox"/> CLARK      | <input type="checkbox"/> HARRISON  | <input type="checkbox"/> MONROE     | <input type="checkbox"/> TRUMBULL   |
| <input type="checkbox"/> CLERMONT   | <input type="checkbox"/> HENRY     | <input type="checkbox"/> MONTGOMERY | <input type="checkbox"/> TUSCARAWAS |
| <input type="checkbox"/> CLINTON    | <input type="checkbox"/> HIGHLAND  | <input type="checkbox"/> MORGAN     | <input type="checkbox"/> UNION      |
| <input type="checkbox"/> COLUMBIANA | <input type="checkbox"/> HOCKING   | <input type="checkbox"/> MORROW     | <input type="checkbox"/> VAN WERT   |
| <input type="checkbox"/> COSHOCTON  | <input type="checkbox"/> HOLMES    | <input type="checkbox"/> MUSKINGHAM | <input type="checkbox"/> VINTON     |
| <input type="checkbox"/> CRAWFORD   | <input type="checkbox"/> HURON     | <input type="checkbox"/> NOBLE      | <input type="checkbox"/> WARREN     |
| <input type="checkbox"/> CUYAHOGA   | <input type="checkbox"/> JACKSON   | <input type="checkbox"/> OTTAWA     | <input type="checkbox"/> WASHINGTON |
| <input type="checkbox"/> DARKE      | <input type="checkbox"/> JEFFERSON | <input type="checkbox"/> PAULDING   | <input type="checkbox"/> WAYNE      |
| <input type="checkbox"/> DEFIANCE   | <input type="checkbox"/> KNOX      | <input type="checkbox"/> PERRY      | <input type="checkbox"/> WILLIAMS   |
| <input type="checkbox"/> DELAWARE   | <input type="checkbox"/> LAKE      | <input type="checkbox"/> PICKAWAY   | <input type="checkbox"/> WOOD       |
| <input type="checkbox"/> ERIE       | <input type="checkbox"/> LAWRENCE  | <input type="checkbox"/> PIKE       | <input type="checkbox"/> WYANDOT    |

A) This provider agreement (Agreement) is a contract between the Ohio Department of Medicaid (ODM) and the undersigned provider of HOME Choice services (the Provider) in which the Provider agrees to provide covered services associated with the provider type(s) identified on page one under the HOME Choice Demonstration Program. By signing this Agreement, the Provider agrees to comply with the terms of this Agreement, federal and state laws, federal and state program requirements, and other requirements as required by ODM. The Provider also specifically agrees to:

- 1) Meet all HOME Choice provider requirements set forth in Chapter 5160-51 of the Ohio Administrative Code.
- 2) Render HOME Choice services in accordance with Chapter 5160-51 of the Administrative Code and as authorized in the HOME Choice participant's HOME Choice service plan, and only in the amount required by the participants, without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap.
- 3) Submit claims only for services actually performed and bill in accordance with rule 5160-51-06.
- 4) Make contact with the HOME Choice participant in order to initiate service provision within 5 business days of receiving authorization from ODM's HOME Choice Operations Unit.
- 5) Render the services covered under this Agreement, and to not sub-contract any services under this Agreement without the prior, written consent of ODM.
- 6) Follow all ODM-approved reimbursement policies and procedures established for the HOME Choice financial management services (FMS) provider for all HOME Choice Services, including submission of claims within 90 days of service.
- 7) Accept the allowable payment for the contracted service as payment-in-full and not seek additional reimbursement for the services from ODM, the participant, guardian, any member of the family, or any other person or entity.
- 8) Maintain all participant records necessary, and in such form so as to fully disclose the extent of services provided, for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer. At a minimum, each participant's record must contain:
  - a) Copies of the HOME Choice participant's service plans showing provider authorization; and
  - b) Copies of provider notes including; dates of services, time of services (begin and end times), validation of service delivery which must include the dated signature of both the provider and the HOME Choice participant, and any other documents related to the services delivered.
- 9) Act in a prompt and professional manner at all times under this Agreement.
- 10) Furnish to ODM, the Secretary of the U.S. Department of Health and Human Services, or the Health Care Fraud Section of the Ohio Attorney General, or their designees, any information maintained under paragraph 8 (above) for purposes of an audit or any other purpose within 30 days of the request for such information.
- 11) Inform ODM within thirty days of any changes to the information provided in the HOME Choice Demonstration Program Provider Enrollment Application/Time Limited Agreement (ODM 02216) (*e.g.*, change in ownership and/or control; change in address or phone number, etc.).
- 12) Have accurately disclosed in the application section on page two of this document the ownership and control information, and the identity of any person with ownership or control interest (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended,) who has been convicted of a criminal offense related to Title XVIII, Title XIX, or Title XX Services.

- 13) Comply with the criminal record check requirements set forth in Chapter 5160-51 of the Administrative Code.
  - 14) Ensure that staff providing direct participant contact:
    - a) Have knowledge about and experience with local community resources and applicable disability laws and regulations.
    - b) Embrace participant self-determination
    - c) Possess experience advocating on behalf of participants with disabilities.
    - d) Are eighteen years of age or older.
    - e) Meet the qualifications outlined in the 5160-51-04 for the specific provider type.
  - 15) Have accurately disclosed in the application section of this document whether the Provider has been sanctioned, or is currently subject to sanction under the Medicare or Medicaid programs, or otherwise is prohibited from providing services to Medicare or Medicaid beneficiaries.
  - 16) Comply with the policies and procedures governing HOME Choice including the conditions for participation as set forth in Chapter 5160-51 of the Ohio Administrative Code.
  - 17) Comply with incident reporting requirements in accordance with 5160-51-03, and follow the Protection from Harm guidelines provided by ODM's HOME Choice Operations Unit. Any incidents that are discovered during a contact/visit should be reported by the Provider to the HOME Choice case manager or to the waiver case manager within twenty-four hours of discovery.
- B) ODM reserves the right to place the Provider on probationary status if it has any concerns about its performance under this Agreement. The purpose of placing the Provider on probationary status is to encourage and ensure compliance with this Agreement, as well as to ensure the health and welfare of HOME Choice participants. Examples of situations that may lead to being placed on probationary status include, but are not limited to: failing to comply with this Agreement; failing to act promptly and professionally; being the subject of participant complaints; failing to act in a participant's best interest. While on probationary status, the Provider shall continue providing HOME Choice services under this Agreement to participants for whom the Provider has previously accepted; however, the Provider will not receive additional referrals. The Provider will be removed from probationary status and be eligible to receive new referrals upon satisfactorily demonstrating to ODM that the issue which led to the probationary status has been addressed.
- C) The HOME Choice Demonstration Program is not a Medicaid program. This Agreement does not permit the Provider to furnish medical assistance services through the Ohio Medicaid Program.
- D) This Agreement supersedes any and all previous agreements for this service, whether written or oral, between the parties.
- E) ODM or its designee may recoup any overpayment by deducting that amount from a current or future payment. Overpayments include, but are not limited to payments made in error, payments for services that were not authorized, payments for services that were authorized but not provided, and payments that were made as a result of inaccurate billing.
- F) This Agreement is intended to remain in effect for the duration of the HOME Choice Demonstration Program; however, the Agreement may be terminated by either party upon written notice to the other party no less than 30 days prior to the termination date. The Provider, upon receipt of written notice of

termination, shall immediately cease provision of services under this Agreement unless otherwise directed by ODM.

- G) The Provider understands and agrees that no officer, member, employee or agent shall take any action, or cause ODM to take any action, which is inconsistent with the applicable Ohio ethics and conflict of interest laws, including those provisions found in Chapter 102 and Chapter 2921 of the Ohio Revised Code.
- H) The undersigned certifies that he/she is the owner, officer, chief executive officer, or general partner of the organization that is applying to provide services as part of the HOME Choice Demonstration Program. The undersigned agrees to be bound by this Agreement, and confirms that the information he/she has provided is true and accurate.

Name and Title <i>(Please Print)</i>	
Signature	Date