# APPLICATION TO PROVIDE ENVIRONMENTAL MODIFICATION SERVICES

The Community Long Term Care (CLTC) Program enrolls qualified licensed companies to provide Environmental Modification/Pest Control services to Medicaid recipients. These services are prior authorized by CLTC case managers. The authorization includes the service and cost of the service to be provided. Enrolling as a provider of Environmental Modification services allows the provider to serve the following groups:

- Community Choices Waiver Participants;
- HIV/AIDS Waiver Participants;
- Mechanical Ventilation Waiver Participants;

In addition, providers may provide environmental modification services to participants in three waivers that the Department of Disabilities and Special Needs (DDSN) oversees: Pest Control is not a service in these waivers.

- Mental Retardation/Related Disabilities Waiver Participants
- Head and Spinal Cord Injured Waiver Participants.
- Community Supports Waiver Participants

For these waiver programs, DDSN will authorize services.

Providers must follow the General Ramp Specifications and Bath Safety Specifications for each of these services, as well as meeting all other enrollment criteria. In addition, modifications that are bid will be awarded to the lowest bidder. The Specifications for ramps and bath safety products can be found on this web site. You should print a copy to review before completing this application.

For ramps, bath safety products, and pest control each participant is required to choose a provider from a CLIENT CHOICE OF PROVIDER FORM that lists all CLTC providers in the area by county. Because of the client choice of provider policy we cannot guarantee the number of CLTC Participants any provider will be authorized to serve. Therefore, we urge all providers not to rely upon Medicaid as the primary source for reimbursement. **Business decisions should not be made based on any company's or individual's anticipation of receiving any referrals from CLTC**.

In order to complete an application, print this document. Check the appropriate boxes and fill in the information that is requested. You must also include the items listed in addition to completing this application.

Applications should be sent to: **Division of Community Long Term Care- Waiver Management, Post Office Box 8206, Columbia, SC 29202-8206, Attention: Chaini Demas**. If you have any questions regarding this process or the stated requirements, please call Chaini Demas at (803) 898-2709 or Tony Matthews at (803) 898-2712.

**The following items must be checked and/or enclosed for this application to be considered for processing:**

I wish to become a provider of the following services: (Check all for which you are applying)

- ❑ Environmental Modifications
- ❑ Bath Safety Products
- ❑ Pest Control

❑ I agree to abide by all requirements and policies of the Department of Health and Human Services as described in my enrollment and any other communication received from DHHS.

❑ I certify that neither I, nor any officer, director, administrator, billing agent, managing employee, affiliated person or partner, or shareholder having an ownership interest has been involuntarily terminated or has involuntarily withdrawn from participation in the CLTC Program within the last three (3) years.

❑ By checking this box I am indicating that my agency requires Medicaid participants to sign agreements. (Leave blank if this is not the case.) I understand that I must include copies of all agreements with this provider application.

❑ I certify that I am responsible for my any subcontractors.

❑ The county or counties in which my agency plans to provide services are listed on the attached sheet:

❑ I understand that this company may be reviewed by DHHS at any time during normal business hours. This review can be announced or unannounced. I also understand that my company must produce all requested records related to the administration of the agency, staff records and individual participant records.

❑ I understand that I must use the Care Call system to document service delivery and adherence to this enrollment.

❑ I understand that I must not give any type of gifts, samples or other products to CLTC case managers or other CLTC employees.

❑ I understand that I must report incidents of abuse, neglect or exploitation of adult beneficiaries in accordance with the Omnibus Adult Protection Act (S.C. Code of Laws Section 43-35-5, et seq.).

❑ I understand that I will be required to attend a training session at SCDHHS prior to the initiation of a contract.

The name of the person who will sign the enrollment: _____

The name of the person designated to serve as the agency administrator: _____

The following items must be submitted with your application:

- You must submit certified evidence of not less than $10,000.00 operating capital that will show that the provider has the capability to operate for a minimum of 60 days in the event Medicaid reimbursement is delayed or withheld for any reason. This must be a written statement from an officer of a financial institution or a certified accountant; a copy of your most recent bank statement must be included. Operating capital may be verified prior to final approval of enrollment.

- A copy of the provider company's Workers' Compensation Insurance Policy. If you do not yet have one, please indicate on your application. A copy of the policy must be presented prior to the provision of services.

- A copy or letter of certification of the provider company's current liability insurance Policy showing coverage to include date of application.

- A copy of your Residential Contractor's license or General Contractor's license.

- A copy of your Employer Identification Number (EIN) confirmation letter.

- A completed Pre-contractual Information Form. (See attached form)

I certify that all information given with this application is true. I understand that any false information will result in this application being denied.

_____ _____ _____

**Applicant's signature** **Title** **Date**

_____

**Applicant's Name Printed**

**Company Telephone Number** _____

**Company Fax Number** _____

**Alternate Telephone/Cell Number** _____

**Company Name**_____

**Company address**_____

_____

_____

**Mailing address if different from Company address:**

_____

_____

**Email address:** _____

## List of Scheduled Holidays

Check each holiday observed by your agency and indicate additional holidays below.

- ❑ New Year's Day
- ❑ Martin Luther King's Birthday
- ❑ Presidents Day
- ❑ Good Friday
- ❑ Easter
- ❑ Monday after Easter
- ❑ Memorial Day
- ❑ Independence Day (July 4th or day observed)
- ❑ Labor Day
- ❑ Veterans Day
- ❑ Columbus Day
- ❑ Thanksgiving
- ❑ Day after Thanksgiving
- ❑ Christmas Eve
- ❑ Christmas
- ❑ Day after Christmas

List additional holidays here:

_____

_____

## Counties Served

Put a check next to every county in which you intend to provide services. Remember that you must be able to demonstrate that you have a nurse close enough to the county to meet the geographical scope requirements.

- ☐ Abbeville
- ☐ Aiken
- ☐ Allendale
- ☐ Anderson
- ☐ Bamberg
- ☐ Barnwell
- ☐ Beaufort
- ☐ Berkeley
- ☐ Calhoun
- ☐ Charleston
- ☐ Cherokee
- ☐ Chester
- ☐ Chesterfield
- ☐ Clarendon
- ☐ Colleton
- ☐ Darlington
- ☐ Dillon
- ☐ Dorchester
- ☐ Edgefield
- ☐ Fairfield
- ☐ Florence
- ☐ Georgetown
- ☐ Greenville
- ☐ Greenwood
- ☐ Hampton
- ☐ Horry
- ☐ Jasper
- ☐ Kershaw
- ☐ Lancaster
- ☐ Laurens
- ☐ Lee
- ☐ Lexington
- ☐ McCormick
- ☐ Marion
- ☐ Marlboro
- ☐ Newberry
- ☐ Oconee
- ☐ Orangeburg
- ☐ Pickens
- ☐ Richland
- ☐ Saluda
- ☐ Spartanburg
- ☐ Sumter
- ☐ Union
- ☐ Williamsburg
- ☐ York
- ☐ Statewide

Pre-Contractual Information Form

Have you ever worked for an agency that has received Medicaid funds? _____

If yes, what agency and what was your position? _____

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Have you have ever been an enrolled or contracted Medicaid provider?
If yes, when (dates)_____ Which state? _____ What service did you provide?_____
What was/is your previous/current Medicaid provider number?_____
Are you currently enrolled or contracted with DHHS for any service provision? _____
If not, when did contract or enrollment end?_____
If terminated, was termination voluntary or involuntary?_____
If this is an agency or corporate entity, has the agency ever been enrolled or contracted with Medicaid? If yes, when? (dates)_____ Which state?_____
What type of service was provided?_____

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What was/is the agency's or corporate entity's previous/current Medicaid provider number?_____

Have any officers, agents or employees been terminated, been denied participation in the Medicaid Program or denied a contract with DHHS?_____
If yes, when? (dates) _____ For what service? _____Reason?

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*Any falsification of information submitted is grounds for denial or termination of a contract.*

_____ _____
Signature Date

# SAMPLE ORGANIZATIONAL CHART

President

Name:_____

Chief Executive Officer

Name:_____

Chief Financial Officer

Name:_____

Chief Operations Officer

Name:_____

Supervisor

Name:

_____

Supervisor

Name:

_____

Supervisor

Name:

_____

Supervisor

Name:

_____

Supervisor

Name:

_____

Supervisor

Name:

_____

*This chart is only a sample and may not apply to the organizational structure of your company. You may utilize this chart or create your own that more closely represents the organizational structure of your company.