FRAIL ELDER WAIVER PROVIDER APPLICATION
HELPFUL TIPS
FOR COMPLETING THE MASSHEALTH REQUIRED FORMS

MassHealth Provider Forms

I. Frail Elder Home and Community Based Service Waiver Provider Application Form

- Please answer questions 1 thru 19.
- For some applicants, the Provider Name and Legal Entity may be the same. An Individual Provider would have the same provider name and legal entity name. For corporations or agencies, the provider name may be different then the legal entity name.
- Definition of Legal Entity name and address: what is stated on IRS letter and/or Secretary of State's letter as an approved business in Massachusetts
- For Question 17, if you answered "yes" please complete the "list of MassHealth Provider Identification Numbers" form. Please sign and date this form.
    - ASAPs: Please complete your section of this form and submit it with the applications.

  This suggested "List of MassHealth Provider Identification Numbers" form can be used as a reference for your response to Part A in the Federally Required Disclosure form.

  Please Note: You may already have a MassHealth Provider number that allows you to provide services for a MassHealth program. You still need to complete these three enclosed MassHealth forms because you will need a separate MassHealth Waiver Provider number in order to provide Frail Elder HCBS waiver services.

- This Waiver Provider Application must have a live/wet signature. If you are completing the form on-line then you should print the form, sign the form and mail the completed form with the original signature to the address found on the Frail Elder HCBS Waiver Provider Application.

II. Massachusetts Medicaid Program Provider Agreement and Acknowledgement of Terms of Participation for Frail Elder Waiver Home and Community-Based Services Waiver Providers Form

- Please be sure to complete your Provider Name and Address information on the first page. The provider name and address is your "doing business" name and address.
- Page three of this form:
  1. Provider's signature – If you are an Individual Provider then you would sign your name. If you are an Organization/Agency Provider then the CFO or Executive Director may be the person signing this form.
  2. You are required to print legal name of the provider and print legal name of individual signing. The legal name of the provider is the name stated on the IRS letter and Secretary of State's letter as an approved business in Massachusetts.
- <u>This Provider Agreement form must have a live/wet signature</u>. Again, if you are completing the form on-line then you should print the form, sign the form and mail the completed form with the original signature to the address found on the Frail Elder HCBS Waiver Provider Application.

III. Federally Required Disclosure Form

- Section IV Disclosures (p.4)

  I. Part A. *Identification Information*; Please complete name, address and, if applicable, any existing MassHealth Provider ID numbers, including locations. If you do not have any existing MassHealth Provider ID numbers then please indicate **NONE**.

  II. Part B. *Ownership Control* question (1) p.5-6, it is required that you complete and include all personal information (home address, SSN, and DOB for any individual with ownership and/or control interest this includes: Owners, Executive Directors and Officers of the Board of Directors. If there is no person or entity in this category, then you would enter **NONE** in 1 (a) and (b).

III. Part B. *Ownership Control* question (2) p.6-7, if there are no such relationships please indicate, **None**. This is important because if you leave this blank or indicate not applicable the application will be denied and returned.

IV. Part B. *Ownership Control* question (3) p.7; please indicate anyone listed in question 1 as having ownership or control interest in another entity. If there is no such interest, please enter **None**. This is important because if you leave this blank or indicate not applicable the application will be denied and returned.

V. Part B. Ownership Control question (4) p.7-8, it is required that you complete and include all personal information (home address, SSN, DOB) for any managing employee. If there are no managing employees, please enter **None**. This is important because if you leave this blank or indicate not applicable the application will be denied and returned.

VI. Part C. *Business Transactions* p.8, you may skip Part C but in question (1) and (2) please enter **None.** This is important because if you leave this blank or indicate not applicable the application will be denied and returned.

VII. Part D. *Criminal Convictions* p.9, if there are no criminal convictions then please enter **None.** This is important because if you leave this blank or indicate not applicable the application will be denied and returned.

VIII. Part E. *Relationships to Excluded, Penalized or Convicted Persons in accordance with 42 CFR 1002.3* p.11-12, if there are no people with such interest, please enter **None.** This is important because if you leave this blank or indicate not applicable the application will be denied and returned.

- Part F. *Provider Signature and Date* p.12, this Federally Required Disclosure form must have a live/wet signature. Again, if you are completing the form on-line then you should print the form, sign the form and mail the completed form with the original signature to the address found on the Frail Elder HCBS Waiver Provider Application.

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IV. Data Collection Form and Registration Instructions

- Please be sure to complete your Provider Name on the first page.
- In order to obtain a user ID and password to conduct business with MassHealth electronically, you must identify a Primary user. Once you have identified a Primary user then enter the Primary user's name, date of birth, user defined unique four digit PIN, e-mail address, phone number and, if applicable, existing Virtual Gateway ID on this form.
- This Data Collection form must have a live/wet signature. Again, if you are completing the form on-line then you should print the form, sign the form and mail the completed form with the original signature to the address found on the Frail Elder HCBS Waiver Provider Application.