



APPLICATION FOR PROVIDER CERTIFICATION AGED AND DISABLED WAIVER (A&D) TRAUMATIC BRAIN INJURY WAIVER (TBI)

State Form 55512 (R2 / 11-18)

Attention: Waiver / Provider Analyst
FAMILY AND SOCIAL SERVICES ADMINISTRATION
INDIANA HEALTH COVERAGE PROGRAMS (IHCP)
 DA Home and Community-Based Services Waivers
 402 West Washington Street, Room W382, MS 07
 P.O. Box 7083
 Indianapolis, IN 46207-7083

- INSTRUCTIONS:**
1. Mail the completed, signed and dated documents to the FSSA Division of Aging at the above address, or e-mail them to daproviderapp@fssa.in.gov.
 2. Retain copies of all documents mailed to the FSSA Division of Aging.
 3. If you have any questions regarding the completion of the packet, please visit the website at <http://www.in.gov/fssa/da/3476.htm> or contact a waiver provider specialist in the FSSA Division of Aging at (317) 232-4650 or e-mail daproviderapp@fssa.in.gov.

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|--|--|--|--|---|
| Date of application (month, day, year) | | Type of application (check one) <input type="checkbox"/> New application <input type="checkbox"/> Change of ownership <input type="checkbox"/> Add service(s) | | |
| Name of applicant | | | | |
| Telephone number () () | | Fax number () () | | E-mail address |
| Legal business name of applicant | | | | |
| Doing business as (DBA) name of applicant | | | | |
| Legal status of provider (check one) <input type="checkbox"/> Individual / sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership | | | | |
| Indiana State Department of Health (ISDH) license number | | Name license issued to | | |
| Name of Chief Executive Officer (CEO) / administrator / owner | | | | |
| Name of contact person | | | Title | |
| Physical location (number and street, city, state, and ZIP code) | | | | |
| Mailing address (if different from above) (number and street or Post Office box, city, state, and ZIP code) | | | | |
| Type of waiver in which you wish to provide services (check all that apply) <input type="checkbox"/> Aged and Disabled (A&D) (** only) <input type="checkbox"/> Traumatic Brain Injury (TBI) (* only) | | | | |
| Service(s) you plan to provide (check all that apply) | | | | |
| <input type="checkbox"/> Adult Day Services | <input type="checkbox"/> Adult Family Care | <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Attendant Care | <input type="checkbox"/> Behavior Management* |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Environment Modification Assessment** | <input type="checkbox"/> Environmental Modifications | <input type="checkbox"/> Healthcare Coordination | <input type="checkbox"/> Home Delivered Meals |
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Personal Emergency Response System | <input type="checkbox"/> Residential Based Habilitation* | <input type="checkbox"/> Respite | <input type="checkbox"/> Specialized Medical Equipment and Supplies |
| <input type="checkbox"/> Structured Day Program* | <input type="checkbox"/> Structured Family Caregiving** | <input type="checkbox"/> Supported Employment* | <input type="checkbox"/> Transportation | <input type="checkbox"/> Vehicle Modifications |
| <input type="checkbox"/> Secure Memory Care Unit | | | | |
| County(ies) in which you plan to provide service(s) (check all that apply) | | | | |
| <input type="checkbox"/> 01 Adams | <input type="checkbox"/> 02 Allen | <input type="checkbox"/> 03 Bartholomew | <input type="checkbox"/> 04 Benton | <input type="checkbox"/> 05 Blackford |
| <input type="checkbox"/> 06 Boone | <input type="checkbox"/> 07 Brown | <input type="checkbox"/> 08 Carroll | <input type="checkbox"/> 09 Cass | <input type="checkbox"/> 10 Clark |
| <input type="checkbox"/> 11 Clay | <input type="checkbox"/> 12 Clinton | <input type="checkbox"/> 13 Crawford | <input type="checkbox"/> 14 Daviess | <input type="checkbox"/> 15 Dearborn |
| <input type="checkbox"/> 16 Decatur | <input type="checkbox"/> 17 DeKalb | <input type="checkbox"/> 18 Delaware | <input type="checkbox"/> 19 Dubois | <input type="checkbox"/> 20 Elkhart |
| <input type="checkbox"/> 21 Fayette | <input type="checkbox"/> 22 Floyd | <input type="checkbox"/> 23 Fountain | <input type="checkbox"/> 24 Franklin | <input type="checkbox"/> 25 Fulton |
| <input type="checkbox"/> 26 Gibson | <input type="checkbox"/> 27 Grant | <input type="checkbox"/> 28 Greene | <input type="checkbox"/> 29 Hamilton | <input type="checkbox"/> 30 Hancock |
| <input type="checkbox"/> 31 Harrison | <input type="checkbox"/> 32 Hendricks | <input type="checkbox"/> 33 Henry | <input type="checkbox"/> 34 Howard | <input type="checkbox"/> 35 Huntington |
| <input type="checkbox"/> 36 Jackson | <input type="checkbox"/> 37 Jasper | <input type="checkbox"/> 38 Jay | <input type="checkbox"/> 39 Jefferson | <input type="checkbox"/> 40 Jennings |
| <input type="checkbox"/> 41 Johnson | <input type="checkbox"/> 42 Knox | <input type="checkbox"/> 43 Kosciusko | <input type="checkbox"/> 44 LaGrange | <input type="checkbox"/> 45 Lake |
| <input type="checkbox"/> 46 LaPorte | <input type="checkbox"/> 47 Lawrence | <input type="checkbox"/> 48 Madison | <input type="checkbox"/> 49 Marion | <input type="checkbox"/> 50 Marshall |
| <input type="checkbox"/> 51 Martin | <input type="checkbox"/> 52 Miami | <input type="checkbox"/> 53 Monroe | <input type="checkbox"/> 54 Montgomery | <input type="checkbox"/> 55 Morgan |
| <input type="checkbox"/> 56 Newton | <input type="checkbox"/> 57 Noble | <input type="checkbox"/> 58 Ohio | <input type="checkbox"/> 59 Orange | <input type="checkbox"/> 60 Owen |
| <input type="checkbox"/> 61 Parke | <input type="checkbox"/> 62 Perry | <input type="checkbox"/> 63 Pike | <input type="checkbox"/> 64 Porter | <input type="checkbox"/> 65 Posey |
| <input type="checkbox"/> 66 Pulaski | <input type="checkbox"/> 67 Putnam | <input type="checkbox"/> 68 Randolph | <input type="checkbox"/> 69 Ripley | <input type="checkbox"/> 70 Rush |
| <input type="checkbox"/> 71 St. Joseph | <input type="checkbox"/> 72 Scott | <input type="checkbox"/> 73 Shelby | <input type="checkbox"/> 74 Spencer | <input type="checkbox"/> 75 Starke |
| <input type="checkbox"/> 76 Steuben | <input type="checkbox"/> 77 Sullivan | <input type="checkbox"/> 78 Switzerland | <input type="checkbox"/> 79 Tippecanoe | <input type="checkbox"/> 80 Tipton |
| <input type="checkbox"/> 81 Union | <input type="checkbox"/> 82 Vanderburgh | <input type="checkbox"/> 83 Vermillion | <input type="checkbox"/> 84 Vigo | <input type="checkbox"/> 85 Wabash |
| <input type="checkbox"/> 86 Warren | <input type="checkbox"/> 87 Warrick | <input type="checkbox"/> 88 Washington | <input type="checkbox"/> 89 Wayne | <input type="checkbox"/> 90 Wells |
| <input type="checkbox"/> 91 White | <input type="checkbox"/> 92 Whitley | | | <input type="checkbox"/> State Wide |
| Please attach the following documents: | | | | |
| <input type="checkbox"/> 1. W-9 Tax Identification Number | | | | |
| <input type="checkbox"/> 2. Secretary of State letter of authorization to conduct business in Indiana (agencies only) | | | | |
| <input type="checkbox"/> 3. Verification of liability insurance as required by 455 IAC 2-6-2, 455 IAC 2-12-1(4) (vehicle insurance), and 455 IAC 2-11-1 (property and personal Liability insurance) | | | | |
| <input type="checkbox"/> 4. Organizational Chart (agencies only) | | | | |
| <input type="checkbox"/> 5. Copy of Home Health Aide Agency License or Personal Services Agency License (if applicable) | | | | |
| <input type="checkbox"/> 6. All required documents as specified in the provider requirements table located at http://www.in.gov/fssa/da/3476.htm#jump_provider | | | | |
| Have you read the following documents? | | | | |
| <input type="checkbox"/> 1. DA HCBS Waiver Provider Manual: http://provider.indianamedicaid.com/general-provider-services/manuals.aspx <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| <input type="checkbox"/> 2. The Aging Rule: http://www.in.gov/legislative/iac/T04550/A00020.PDF <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Signature of authorized representative | | | Date (month, day, year) | |
| Typed or printed name of authorized representative | | | Title | |