Elderly & Disabled Waiver
In-Home Respite Service
Provider Proposal Packet

Division of Medicaid
Office of Long Term Care
Walter Sillers Building
550 High Street, Suite 1000
Jackson, Mississippi 39201

Contact:

LaTonya Stafford
Operations Management Analyst, Principal
Office of Long Term Care
601-359-6141
HCBSProviders@medicaid.ms.gov

Date of Submission:	
Company Name:	
Contact Name:	
Contact Number:	

Program Introduction

The purpose of In-Home Respite services is to provide non-medical care and supervision to the participant in the absence of the participant's primary full time live-in care giver on a short-term basis. These services are to assist the care giver during a crisis situation and/or as scheduled relief to the primary care giver to prevent, delay or avoid premature institutionalization of the participant.

In-Home Respite services are supportive services provided or accomplished in the home by a trained respite provider that involves one or more of the following primary duties:

- companionship,
- support or general supervision,
- feeding,
- and personal care needs.

THIS IS NOT A PROGRAM FOR ALL MEDICAID RECIPIENTS.

- The Elderly and Disabled Waiver provides services to individuals who, without the provision of such services, would require the level of care found in a nursing facility.
- For In-Home Respite services to be reimbursed by Medicaid, the recipient receiving the services must be enrolled in the Elderly and Disabled Waiver Program.
- Enrollment into this program is approved through the DOM Office of Long Term Care. If individuals meet all criteria for the Waiver program and the Plan of Services and Supports is approved, the participant's case manager will make appropriate referrals for needed services to provider agencies.
- Participants always have freedom of choice of providers.
- Please note, becoming a Medicaid provider does not guarantee that E & D Waiver participants will select your agency.
- **Services provided prior to the issue date of a valid provider number or prior to the receipt of a referral from the case management agency will not be reimbursed.**

Proposal Criteria

For the purpose of this proposal, an agency/business is defined as a legally recognized organization designed to provide services in exchange for money. Services are defined, for this proposal purpose, as the E&D Waiver Service for which you are requesting a provider number.

Upon receipt, your proposal will be date stamped and scanned. In order to process the proposals more efficiently, certain information must be provided in a specific format.

1. All forms must be completed entirely.
2. Forms should be typed, and must be legible.
3. Proposals should be placed in a folder or binder clip.
4. Do not staple, bind, or place documents in sheet protectors.
5. Do not attach tabs or labels to any pages.

All proposals must be submitted to the Division of Medicaid, Office of Long Term Care, Walter Sillers Building, 550 High Street, Suite 1000, Jackson, MS 39201. The proposal will be reviewed and if approved, you will receive information on how to proceed with provider enrollment. During review, if it is determined that the proposal packet is incomplete or lacking specific information, a letter outlining the deficiencies will be sent. Please note that the packet will not be returned to the applicant. Denied proposals must be resubmitted in their entirety and will be treated as initial applications to be reviewed in the order of date received. If clarifications regarding your proposal are needed, you will be contacted by the Division.

If you have question on any of the above, please feel free to contact the Division of Medicaid, Office of Long Term Care by email at HCBSProviders@medicaid.ms.gov. Thank you for your interest in becoming a service provider.

In-Home Respite Services
Provider Agency Description

Business Name:		
Office Mailing Address:		
Office Phone:	**Office Fax:**	
Owner(s) Name:	**Phone:**	
Contact Person's Name:	**Phone:**	
Legal Status:	☐ Private for Profit ☐ Public (State or local government) ☐ Non-Profit ☐ Other (Specify) _____	
Year Established	**Current No. of Individuals Served**	**Anticipated No. of Individuals to be Served**
Current Licenses:		
Office Locations	**Physical Address**	**Counties to be Served from That Office**
Main Office:		
Satellite Office 1:		
Satellite Office 2:		
Satellite Office 3:		
If additional space is needed, please attach additional sheet. Must be typed.		

Required Attachments Checklist

☐	Certificate of Completion of Mandatory Provider Orientation.
☐	Most recent national fingerprint criminal background check results for all staff.
☐	Most recent Office of Inspector General (OIG) check results for all staff.
☐	Most recent Mississippi Nurse Aide Abuse Registry check results for all staff.
☐	Agency organizational chart including names of all staff for each position.
☐	Federal Employer Identification number approval letter with effective date. Dates must be legible.
☐	Filed Federal Business Tax Return for In Home Respite Agency from most current tax year.
☐	Itemized In Home Respite Agency Expense Report.
☐	Business Privilege Tax License for each office location.
☐	Detailed job descriptions for both the respite supervisors and respite providers.
☐	Resumes for agency's signatory authority(ies), management team and supervisory staff to include qualifications, work experience, and education.
☐	Letter from reputable financial institution showing business line of credit to cover total operational costs/expenditures for at least (3) months.
☐	Current, original, signed letters of support from three (3) citizens in the community that can verify your agency's work in providing in home respite service. Must include contact information for verification purposes.

Current Annual Operating Budget

*Attach expense report as well as tax return to support figures below.

Current Funding Sources	
Private Pay:	$
Private Insurance:	$
Financial Loan:	$
Personal Income:	$
Other Source (Specify): _____:	$
Total Annual Income:	$

Current Salary Expenses			
Job Title	Annual Salary for Title	Number of Positions	Total Annual Salaries for All Staff in this Position
1.			$
2.			$
3.			$
4.			$
5.			$
6.			$
7.			$
8.			$
9.			$
10.			$
Total Current Annual Salary Expense:			$

Current Annual Expenses	
Total Salaries for All Staff (Must match above):	$
Other Payroll Expenditures:	$
Rent/Mortgage/Building:	$
Utilities:	$
Telephone*:	$
Supplies:	$
Equipment:	$
Training:	$
Travel:	$
Loan:	$
Insurance:	$
Membership(s):	$
Other (Specify):_____:	$
Other (Specify):_____:	$
Total Annual Expenses:	$

Total Annual Income	$
Total Annual Expenses	$
Balance (Annual Income minus Annual Expenses = Net Operating Income)	$

* Dedicated landline telephone is REQUIRED for each office.

In-Home Respite Services
Provider Attestation

Each item is required in order to submit this proposal. Please read and initial acknowledging your agreement.

- ❖ Applicant agrees to read and comply with Quality Assurance Standards. _____
- ❖ Applicant agrees to read and adhere to the DOM Administrative Code in its entirety. _____
- ❖ Applicant agrees to have a Policy & Procedures manual available for on-site review. _____
- ❖ Applicant is current on national fingerprint criminal background checks on all employees. _____
- ❖ Applicant is current on monthly Office of Inspector General exclusion list checks for all employees. _____
- ❖ Applicant is current on monthly Mississippi Nurse Aide Abuse Registry checks for all employees. _____
- ❖ Applicant is financially stable. _____
- ❖ Applicant is free from tax liens. _____
- ❖ Applicant has filed a tax return on the In Home Respite business for the current year. _____
- ❖ Applicant has a business line of credit to cover total operational costs/expenditures for at least (3) months. _____
- ❖ Applicant is an established agency and has been in business providing In Home Respite Service for a minimum of one (1) year. _____
- ❖ Applicant has current, original letters of support from three (3) citizens in the community that can verify the agency's work in providing in home respite service. _____
- ❖ Applicant has established a business office in a non-residential location no more than 60 minutes from service area and agrees to maintain this location until provider agreement is terminated. _____
- ❖ Applicant has attended mandatory Provider Enrollment Orientation prior to submitting proposal. _____
- ❖ Applicant has attached all required forms to this application. _____

I understand that incomplete or incorrect information provided will disqualify the application from consideration. As the duly authorized representative, I declare under penalty of perjury that all statements made herein and on any attached documents are true and complete to the best of my knowledge. I further understand that any omission, misrepresentation or falsification of any information contained in this proposal application or contained in any communication supplying information to Medicaid to complete or clarify this proposal application may be punishable by criminal, civil or other administrative actions.

_____	_____	_____
Signature	Print Name (must be legible)	Date