

# Elderly & Disabled Waiver Personal Care Service Provider Proposal Packet



MISSISSIPPI DIVISION OF  
**MEDICAID**

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 Personal Care Services (PCS) is to assist the waiver participant in meeting daily living needs and ensure optimal functioning at home and/or in the community.

PCS are supportive services provided or accomplished in the home by a trained Personal Care Attendant (PCA) that involves one or more of the following primary duties:

- activities of daily living,
- personal hygiene,
- meal preparation not including the cost of meals,
- and housekeeping chores essential to the health and welfare of the participant.

These services may also involve accompanying and assisting the participant in accessing community resources and participating in community activities; supervision and monitoring during non-emergency transportation when medically justified, and in the community setting.

## **THIS IS NOT A PROGRAM FOR ALL MEDICAID RECIPIENTS.**

- The Elderly and Disabled (E&D) Waiver provides services to individuals who, without the provision of such services, would require the level of care found in a nursing facility.
- For PCS to be reimbursed by Medicaid, the recipient receiving the services must be enrolled in the E&D Waiver Program.
- Enrollment into this program is approved through the Division of Medicaid (DOM) Office of Long Term Care. If individuals meet all criteria for the Waiver program and the Plan of Services and Supports (PSS) 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 DOM.

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](mailto:HCBSPROVIDERS@MEDICAID.MS.GOV). Thank you for your interest in becoming a service provider.

## Personal Care Services Provider Agency Description

<b>Business Name:</b>		
<b>Office Mailing Address:</b>		
<b>Office Phone:</b>		<b>Office Fax:</b>
<b>Owner(s) Name:</b>		<b>Phone:</b>
<b>Contact Person's Name:</b>		<b>Phone:</b>
<b>Legal Status:</b>	<input type="checkbox"/> Private for Profit <input type="checkbox"/> Public (State or local government) <input type="checkbox"/> Non-Profit <input type="checkbox"/> Other (Specify) _____	
<b>Year Established</b>	<b>Current No. of Individuals Served</b>	<b>Anticipated No. of Individuals to be Served</b>
<b>Current Licenses:</b>		
<b>Office Locations</b>	<b>Physical Address</b>	<b>Counties to be Served from That Office</b>
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

<input type="checkbox"/>	Certificate of Completion of Mandatory Provider Orientation.
<input type="checkbox"/>	Most recent national fingerprint criminal background check results for all staff.
<input type="checkbox"/>	Most recent Office of Inspector General (OIG) check results for all staff.
<input type="checkbox"/>	Most recent Mississippi Nurse Aide Abuse Registry check results for all staff.
<input type="checkbox"/>	Agency organizational chart including names of all staff for each position.
<input type="checkbox"/>	Federal Employer Identification number approval letter with effective date. Dates must be legible.
<input type="checkbox"/>	Filed Federal Business Tax Return for Personal Care Services Agency from most current tax year.
<input type="checkbox"/>	Itemized Personal Care Service Agency Expense Report.
<input type="checkbox"/>	Business Privilege Tax License for each office location.
<input type="checkbox"/>	Detailed job descriptions for both the personal care attendants and supervisors.
<input type="checkbox"/>	Resumes for agency's signatory authority(ies), management team and supervisory staff to include qualifications, work experience, and education.
<input type="checkbox"/>	Letter from reputable financial institution showing business line of credit to cover total operational costs/expenditures for at least (3) months.
<input type="checkbox"/>	Current, original, signed letters of support from three (3) citizens in the community that can verify your agency's work in providing personal care 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): _____:	\$
<b>Total Annual Income:</b>	<b>\$</b>

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.			\$
<b>Total Current Annual Salary Expense:</b>			<b>\$</b>

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): _____:	\$
<b>Total Annual Expenses:</b>	<b>\$</b>

<b>Total Annual Income</b>	\$
<b>Total Annual Expenses</b>	\$
<b>Balance (Annual Income minus Annual Expenses = Net Operating Income)</b>	<b>\$</b>

\* Dedicated landline telephone is REQUIRED for each office.

# Personal Care 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 Personal Care Service 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 Personal Care 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 personal care 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