State Plan Private Duty Nursing (PDN) and Personal Care Service (PCS) Supplemental Provider Enrollment Packet

Division of Medicaid
Office of Medical Services
Walter Sillers Building
550 High Street, Suite 1000
Jackson, Mississippi 39201

Contact:
Office of Medical Services
601-359-6150
OMS@medicaid.ms.gov

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

Version 4, revised 7/1/2020

Program Information

Private Duty Nursing (PDN) and Personal Care Service (PCS) services are State Plan covered benefits for beneficiaries that are eligible for the Early and Periodic Screening, Diagnosis and Treatment (EPDST) Program. These services must be medically necessary and ordered by a physician.

PDN services are medically necessary skilled nursing care services for EPSDT-eligible beneficiaries who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or skilled nursing facility. The Division of Medicaid's requirements for PDN services and providers can be found in Title 23, Part 223, Chapter 4.

PCS services are medically necessary services for EPSDT-eligible beneficiaries who require assistance in order to safely perform the activities of daily living (ADLs) due to a diagnosed condition, disability, or injury. The delivery and receipt of these services must be medically necessary for the treatment of the beneficiary's condition, disability, or injury and exceed the level of care available through the home health benefit. The Division of Medicaid's requirements for PCS services and providers can be found in Title 23, Part 223, Chapter 5.

Supplemental Enrollment Packet Criteria - ***For the purpose of this packet, an agency/business is defined as a legally recognized organization designed to provide services in exchange for money.***

Hardcopy/Paper Enrollment Packet Submission Requirements - Upon receipt, your Enrollment Packet will be date stamped, logged and scanned. In order to process the Enrollment Packets more efficiently, certain information must be provided in a specific format. All hardcopy/paper Enrollment Packets must be submitted to the Division of Medicaid, Attention: Office of Medical Services, 550 High Street, Suite 1000, Jackson, MS 39201.

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

Electronic Enrollment Packet Submission Requirements – Upon receipt, your Enrollment Packet will be logged. Your Enrollment Packet must contain all completed forms, should be typed, must be legible and all required attachments must be included. Electronic Enrollment Packets must be submitted to OMS@medicaid.ms.gov.

The Enrollment Packet will be reviewed and if approved, you will receive information on how to proceed with provider Enrollment Packet. During review, if it is determined that the Enrollment 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 Enrollment Packets 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 Enrollment Packet are needed, you will be contacted by DOM. If you have questions on any of the above, please feel free to contact the Division of Medicaid, Office of Medical Services by email at OMS@medicaid.ms.gov. Thank you for your interest in becoming a service provider.

Private Duty Nursing (PDN)/Personal Care Service (PCS)

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

☐	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.
☐	Itemized Agency Expense Report.
☐	Business Privilege Tax License for each office location.
☐	Detailed job descriptions for nurses, certified nursing assistants, supervisors, and office staff.
☐	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 one (1) month.
☐	Current, original, signed letters of support from three (3) citizens in the community that can verify your agency's work in providing services. Must include contact information for verification purposes.

Current Annual Operating Budget

*Attach expense report 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.

PDN/PCS
Provider Attestation

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

- ❖ 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 e 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 business line of credit to cover total operational costs/expenditures for one (1) month. _____
- ❖ 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 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 Enrollment Packet application or contained in any communication supplying information to Medicaid to complete or clarify this Enrollment Packet application may be punishable by criminal, civil or other administrative actions.

_____ _____ _____

Signature Print Name (must be legible) Date