Assisted Living Waiver
Traumatic Brain Injury Residential Facility
Provider Proposal Packet

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

Contact:

James Horton
Division Director II
Office of Long Term Care
601-359-6141
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Date of Submission:	
Company Name:	
Contact Name:	
Contact Number:	

TBI Residential Facility
Provider Proposal Criteria

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 Policy & Procedures manual available for on-site review.	
❖ Applicant is current on national fingerprint criminal background check on employees/volunteers.	
❖ 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/volunteers.	
❖ Applicant is financially stable.	
❖ 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

Program Introduction

The Division of Medicaid (DOM) requires entities interested in becoming an approved Traumatic Brain Injury Residential Facility to provide service components that meet the needs identified during the waiver participant's assessment and which are included in the individualized Plan of Services and Supports (PSS). Components must meet the requirements as specified in the current waiver as approved by the Centers of Medicare and Medicaid. The services must include, but are not limited, to the following:

Activities: There must be structured social, therapeutic and recreational activities geared for the needs of the waiver participants provided in an environment that is homelike. Easy access shall be provided to resources and unscheduled activities in the community.

Escort services: There must be trained and competent staff to accompany or personally assist a waiver participant who is unable to travel or wait alone.

Essential Shopping: There must be assistance for obtaining clothing and personal care items for the waiver participant when the participant is unable to do so for him/herself. This does not include financing or purchase of clothing.

Health Maintenance: There must be health maintenance activities performed in accordance with the Nurse Practice Law and the Board of Pharmacy.

Housekeeping services: Services must be available for cleaning the public areas as well as the waiver participant's living unit.

Laundry services: Services must be available to wash, dry, fold and return the waiver participant's clothing to his/her living unit. Dry cleaning costs are the responsibility of the waiver participant but the facility shall assist the participant in arranging the service, if needed.

Dining Service: The facility must provide three meals a day, each providing at least one-third of the recommended daily allowance, to meet the waiver participant's nutritional needs. Snacks must be offered seven days per week and, unless clinically contraindicated, provided upon request between meals.

Medication Oversight and Administration: The facility must provide assistance with the administration of medication in accordance with applicable Laws, Rule and Regulations, and Administrative Codes

Nursing services, except periodic nursing evaluations and medication administration, are incidental, rather than integral to the provision of care.

Personal Care services: The facility must provide the following attendant care services and supports including, but not limited to, the following:

- Bathing, hair care, skin care, shaving, nail care, oral hygiene, overall hygiene and activities of daily living;
- Intervention to assist a waiver participant with eating and bowel and bladder management;
- Assistance with positioning;
- Care of adaptive personal care devices;
- An appropriate level of supervision.

Behavioral services, physical therapy, speech therapy and occupational therapy are an integral part of this service. Coverage for the cost of these services is included in the comprehensive rate. Waiver participants will not be eligible for Medicaid coverage for these services outside of this waiver.

The Division of Medicaid will neither reimburse the participant nor the provider for the cost of room and board.

THIS IS NOT A PROGRAM FOR ALL MEDICAID RECIPIENTS-
For a Traumatic Brain Injury Residential facility to be reimbursed by Medicaid, the waiver participant must be enrolled in the Assisted Living Waiver Program and must meet the following criteria:

- Upon admission into the waiver, must be in a crisis/high stress situation at risk for institutionalization or at risk of being discharged from a facility due to behavioral issues requiring a specialized residential setting.
- Must have a physician certification confirming a diagnosis of an acquired traumatic brain injury which is defined as a traumatically acquired, non-degenerative structural brain damage. The term does not apply to brain injuries that are congenital or those induced by birth trauma.
- Must have completed the acute phase of rehabilitation.
- Must have conditions that are severe, chronic, and disabling, requiring in excess of four hours of care per day but who do not require complex medical interventions.
- Must have ultimate long-term goal to transition to safe, independent living elsewhere in the community, when appropriate.
- Upon admission to the Traumatic Brain Injury Residential Facility, the provider must develop and active and ongoing plan of discharge which strives to assist the waiver participant to gain independence to transition into the community with little or no assistance. DOM case managers will review the status of the waiver participant's progression monthly. Face to face visits will occur, at a minimum, on a quarterly basis.

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 AL 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, but 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 applicants must submit a Mississippi Medicaid Enrollment Application with their proposal. The application may be downloaded at: www.msmedicaid.acs-inc.com/msenvision. 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 DOM. Once the proposal has been reviewed and approved, an on-site review of the facility will be scheduled. DOM staff will contact you with a date for the on-site review of the facility. To help prepare for the on-site review, please review Appendices A, B, C, and D to conduct your own review. If the on-site review is successful, you will receive further instructions from DOM. Approval of your proposal and on-site review does not guarantee approval to be a provider.

If you have question on any of the above, please feel free to contact the Division of Medicaid, Office of Long Term Care at 601-359-6141. Thank you for your interest in becoming a service provider.

Traumatic Brain Injury Residential Facility Service
Provider Agency Description

Business Name:		
Office Mailing Address:		
Office Phone:		**Office Fax:**
Physical Address:		
Owner(s) Name:		**Phone:**
Contact Person's Name:		**Phone:**
Current No. of Individuals Served:		**Year Established:**
Legal Status:	☐ **Private for Profit** ☐ **Public (State or local government)** ☐ **Non-Profit** ☐ **Other (Specify)** _____	
Current Licenses:		
If additional space is needed, please type information and attach an additional sheet. .		

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.			$
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:	$
Food or Catering Contract:	$
Transportation maintenance/operation or Contract:	$
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 the facility.

Required Attachments Checklist

☐	License issued by Department of Health.
☐	National fingerprint criminal background checks for all staff/volunteers.
☐	Most recent Office of Inspector General (OIG) check results for all staff/volunteers.
☐	Most recent Mississippi Nurse Aide Abuse Registry check results for all staff/volunteers.
☐	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 Expense Report.
☐	Business Privilege Tax License, Fire and Safety Permits, Kitchen permits, ordinances, etc.
☐	Detailed job descriptions for all required staff.
☐	Current license and certifications for all staff. (for example, LSW, CNA, LPN, RN, etc.)
☐	Attach a detailed list fully disclosing, the names, address, and phone numbers of any individual maintaining ownership or financial interest in the agency/organization from the period which care services will be provided.
☐	Describe the applicant center or agency's developmental training activities that demonstrates the agency understands the need for trained, competent staff in order to operate a quality care program.