Elderly & Disabled Waiver
Adult Day Care Service
Provider Proposal Packet

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

Contact:

Kenosha Williams
Program Specialist
Office of Long Term Care
601-359-6141
HCBSProviders@medicaid.ms.gov

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

Program Introduction

Adult Day Care (ADC) services include comprehensive program which provides a variety of health, social and related supportive services in a protective setting during the daytime and early evening hours. ADC services must meet the needs of aged and disabled persons through an individualized Plan of Services and Supports (PSS) that includes the following:

1) Personal care and supervision,
2) Provide choices of food and drinks to persons at any time during the day to meet their nutritional needs in addition to the following:
    a) A mid-morning snack,
    b) A noon meal, and
    c) An afternoon snack.
3) Provision of limited health care,
4) Transportation to and from the site and center-sponsored activities, with cost being included in the rate paid to providers, and
5) Social, health, and recreational activities which optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and personal preferences and,
6) Provide information on, and referral to, vocational services.

<u>THIS IS NOT A PROGRAM FOR ALL MEDICAID RECIPIENTS.</u>

- 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 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 proposals must be mailed 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 Adult Day Care Center (ADC) will be scheduled. DOM staff will contact you with a date for the on-site review of the ADC. To help prepare for the on-site review, please review Appendices A, B, C, and D to conduct your own review. If the ADC 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 by email at HCBSProviders@medicaid.ms.gov. Thank you for your interest in becoming a service provider.

Adult Day Care Agency Description & Contact Information

Business Name:		
Office Mailing Address:		**Primary Email Address:**
Office Physical Address:		**List of counties served from this location:**
Office Phone:	**Office Fax:**	**Year Established:**
Owner(s) Name:		**Phone:**
Contact Person's Name:		**Phone:**

Hours of Operation:	Current No. of Individuals Served:
Total number of restrooms in your facility:	How many of these restrooms are ADA compliant:
Total number of stalls per restroom:	Date of most current kitchen permit or food service contract:
Number of vehicles used to transport individuals:	Date of your last fire inspection:
If additional space is needed, please attach additional sheet.	

Job Title	Number of staff in this position	Name(s) of staff in this position
Administrator/CEO/President		
Program Coordinator		
Social Worker		
Registered Nurse		
Activities Coordinator		
Program Assistant		
Secretary/Bookkeeper		
Driver		
Food Service Coordinator (if food prepared on-site) OR Food Service Provider/Caterer		

Adult Day Care Services
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 be compliant with all federal and state regulations including, but not limited to, tax and labor laws.	
❖ 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 is free from tax liens.	
❖ Applicant has attached a filed copy of tax return on the ADC's business for the current year.	
❖ Applicant has a business line of credit to cover operation cost/expenditure for at least (3) months.	
❖ Applicant has been established in a nonresidential facility and has been in business providing Adult Day Care Service for a minimum of one (1) year.	
❖ Applicant has current, signed, original letters of support from three (3) clients or their caregiver that can verify your agency's work in providing adult day care services.	
❖ Applicant has established a business office in a non-residential location no more than 60 minutes from service area.	
❖ Applicant has participated in Virtual Provider Orientation and received a Certificate of Completion before 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

Adult Day Care Services
Required Attachments Checklist
Each item is required in order to submit this proposal. Missing documents will result in denial.

☐	Current Certificate of Completion of Mandatory Provider Orientation.
☐	National fingerprint criminal background check results 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.
☐	A copy of the provider's most current filed tax return for the business along with confirmation verifying it was filed. Examples of acceptable forms of confirmation include: 8879 form from a tax preparer with the submission identification (SID) number 9325 form from the IRS with the submission identification (SID) number
☐	Federal Employer Identification number approval letter with effective date. Dates must be legible.
☐	Itemized Adult Day Care Agency Expense Report reflecting all income and expenditures for each month for the past 12 months. Note, these expenses should be the exact dollar amount and not the same each month.
☐	Business Privilege Tax License, Fire and Safety Permits, Kitchen permits, ordinances, etc.
☐	Letter showing agency has established a business line of credit for business operation from either a financial institution licensed to conduct banking or other financial institution business under the laws of any state. The approval amount for the business line of credit must be enough to cover operational costs/expenditures for at least three (3) months at all branch locations.
☐	Three current, signed, original letters of support from three (3) clients or their caregiver that can verify your agency's work in providing adult day care service.
☐	Detailed job descriptions that include the educational requirements, work experience, job duties and responsibilities for all required staff.
☐	Resumes for the agency's signatory authority(ies) and key staff to include qualifications, work experience, job duties and responsibilities, and education.
☐	Current license and certifications for all staff. (For example, CNA, RN, etc.)
☐	List of applicant center's daily developmental activity schedule.
☐	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.
☐	Indicate if food is prepared on site or catered. If prepared on site enclose a copy of your Kitchen Permit from MSDH. If catered, attach enclose a copy of a detailed, signed, and dated agreement with a reputable catering company licensed by MSDH.
☐	Provide the applicant center or agency's developmental training logs that demonstrates the agency is providing the required training to maintain competent staff in order to operate a quality care program.
☐	Official blueprints or official document outlining the square footage of the ADC's program space.

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:	$
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 telephone is REQUIRED for the facility.