Assisted Living Waiver
Provider Proposal Packet

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

Contact:

LaShonda Barnes
Assisted Living Waiver Director
Office of Long Term Care
601-359-6141
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Date of Submission:	
Company Name:	
Contact Name:	
Contact Number:	
Contact Email:	

Program Introduction

The Division of Medicaid (DOM) requires entities interested in becoming an approved Assisted Living Waiver 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:

Personal Care Services: Services must be rendered by personnel of the licensed facility to assist beneficiary in performing one or more of the activities of daily living, including but not limited to: bathing, walking, excretory functions, feeding, personal grooming, and dressing.

Homemaker Services: Services must consist of general household activities including routine household care of beneficiary's residential unit.

Chore Services: Services must be provided to maintain the beneficiary's residential unit in a clean, sanitary and safe mode.

Attendant Care Services: There must be hands-on care, both of a supportive and health-related nature, specific to the needs of a medically stable, physically disabled beneficiary.

Therapeutic, Social, and Recreational Programing: There must be recreation and leisure experiences to help elderly and/or disabled beneficiaries to increase their physical, mental, emotional and social skills.

Attendant Call System: An emergency response system for beneficiaries who are at risk of falling, becoming disoriented, or experiencing some disorder that puts them in physical, mental or emotional jeopardy. Other individuals or agencies may also furnish care directly, or under agreement with the PCH- AL facility. Care provided by these other entities may supplement services provided by the PCH- AL facility, but they may not be provided in lieu of those provided by the PCH-AL facility.

Transportation Service: The facility must provide transportation services specified in the Plan of Services and Supports for transporting beneficiaries to medical appointments. Transportation services may be provided by the PCH-AL or through the DOM Non-Emergency Transportation (NET) program. Services through NET are available only when the beneficiary has not reached the maximum services limits provided under the State Plan.

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

Intermittent Skilled Nursing Services: Nursing care and interventions rendered to the beneficiary as ordered by the physician must be provided.

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 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 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.

Assisted Living Waiver
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.
☐	Most recent 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.)
☐	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.
☐	A list and description of developmental trainings and activities provided to staff in the past year.

Assisted Living Waiver
Provider Attestation

Each item is required in order to submit this proposal. 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 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