

The New Agency Application

- Applicant's Information (CEO Information) - A provider will only see this screen if they are a brand new provider.

(Please enter the **applicant's** information only)

Please enter your first and last name below.

First Name: *

Middle Initial: (Optional)

Last Name: *

Title: (Optional)

Phone: * (Numbers only)

Please enter one of the following:

(SSN should be filled out if completing an application for Independent Certification)
(TaxID/EIN should be filled out if completing an application for Agency or Sole Proprietor Certification)

SSN TaxID/EIN * (Numbers only)

Please enter your email address and confirm it.

(The email account must not be a shared or group email account)

Email: *

Confirm Email: *

Optional Secondary Contact

(Automated systems will use both emails at all times)

First Name:

Middle Initial:

Last Name:

Secondary Email:

Confirm Secondary Email:

Save and Continue

Documents Required for Certification

Located at the top of the screen is your application number and a list of application tabs.

Please be advised that new services are available for selection on the Services Screen.

[Home](#)

Application Fees: \$75.00

Application ID: 64683 MBS Contract Number: 3109737 Oaks Contract Number: 0000153615

Start	Demographic	Relative / Associate	Service	County of Business	NPI	Disclosure (Page 1 of 2)	Disclosure (Page 2 of 2)	Medicaid Provider Agreement	Attestation	Download Files	Documents Required	Summary	Confirmation
Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	FINISH

- On the Start Tab, you will select your Provider Type.
- On the next slide is the bottom part of the same web page.

[Home](#) Application ID: 64621

Start	Demographic	Relative / Associate	Documents Required	Summary	Confirmation
					FINISH

[Save and Continue](#)

Fee Schedule	Initial Certification (3 years)	Renewal Certification (3 years)	Add Service(s) During Term of Certification	Update Demographic Information
Independent / Sole Proprietor	\$125.00	\$125.00	\$25.00	No Fee
Small Agency	\$800.00	\$800.00	\$75.00	No Fee
Large Agency	\$1,600.00	\$1,600.00	\$150.00	No Fee
ODM Fee Information	\$554.00			
Licensed Facility Only or OOD/RSC Provider Only	No Fee	No Fee	No Fee	No Fee

Provider Type

Please select one

Independent: I am applying for Independent Provider Certification (i.e., I am a self-employed person who intends to provide services and shall not employ, either directly or through contract, anyone else to provide the services).

Independent / Sole Proprietor - (I operate my business under my SSN / Tax ID)

Agency: I am applying for Agency Provider certification (i.e., I am the Chief Executive Officer [CEO] of an entity that employs persons for the purpose of providing services).

Small Agency - (i.e., one that serves or plans to serve 50 or fewer individuals)

Large Agency - (i.e., one that serves or plans to serve 51 or more individuals)

ICF/IID - Intermediate Care Facility

Unpaid: I am applying to become an unpaid provider.

Support Broker (Unpaid) - Only

- Continued from the previous slide.
- On the same page you will see Application Type, and Service Type.

Application Type

Please select one

- I am applying for initial certification.
- I am applying for renewal certification.
- I am applying to add additional HCBS waiver service(s) to term of existing certification.
- I am applying to update my Demographic Information.

Service Type

Please select one

- I am applying for certification to provide HCBS Waiver Services AND Non-Waiver Services.
- I am applying for certification to provide non-waiver services ONLY. ⓘ
- I am currently certified through the Ohio Department of Aging and/or Ohio Department of Job and Family Services and am applying to be a DODD Provider
- I am applying as an ICF to provide non-waiver services. ⓘ
- I am currently providing HCBS Waiver services only in licensed facilities. ⓘ
- I am a provider with a current Provider Agreement with Opportunities for Ohioans with Disabilities Agency (OOD), formerly known as the Rehabilitation Services Commission (RSC), and am applying to be a DODD Provider of Supported Employment--Community and/or Integrated Community. ⓘ

Save and Continue

- The Demographic Tab is where you will enter the CEO information as well as the Agency address(s), contact information, and the number of employees.
- The next two slides contain the bottom half of demographics page.

Start	Demographic	Relative / Associate	Medicaid Fee	Service	County of Business	NPI	Disclosure (Page 1 of 2)	Disclosure (Page 2 of 2)	Medicaid Provider Agreement	Download Files	Documents Required	Summary	Confirmation
Completed	Pending	Pending	Pending	Pending	Pending	Completed	Pending	Pending	Pending	Completed	Pending	Pending	FINISH

Provider Demographic (indicates required data entry)*

Provider Entity Type *

Corporation
 Partnership
 Sole Proprietorship
 Limited Liability Company

Type of Business (Optional)

MBE (Minority Business Enterprise)
 EDGE (Encouraging Diversity, Growth, & Equity)

Provider Name

CEO First Name * MI CEO Last Name *

Provider Information

Name of Agency *

DBA Name of Agency

SSN TaxID/EIN *

Tax Effective Date: * Tax Exempt Status: *

Ownership Type: *

Email Address: *

CEO SSN *

CEO Date of Birth *

Has your CEO lived outside the State of Ohio within the last 5 years (on or after 8/8/2011)? *

Yes No

Does your CEO have a Designee? *

Yes No

- Demographics
Tab continued (2
of 3).

Physical Address

Contact First Name * Middle Name Last Name *

Building Name (or Department / In care of)

Address 1 * (P.O. and Drop Boxes are not acceptable)

Address 2

City * State * Zip Code * -

County * Email Address *

Phone Number * Ext Phone Number2 Ext

Fax Number Fax Number2

Check this box if the Billing and Mailing addresses are the same as this address

Alternative Address

Contact First Name * Middle Name Last Name *

Building Name (or Department / In care of)

Address 1 * (P.O. and Drop Boxes are not acceptable)

Address 2

City * State * Zip Code * -

County * Email Address *

Phone Number * Ext Phone Number2 Ext

Fax Number Fax Number2

Secondary Contact (Optional)

First Name Middle Initial

Last Name

Email Address

- Demographics
Tab continued (3
of 3).

Number Of Agency Employees
Other than the listed CEO, how many employees are employed with the listed agency? *

2 - 5

Individual Waiting For Services
Is there currently an individual waiting for you to be able to provide services? *

Yes No

If yes, please enter the following information below:

Name of individual

Medicaid number

Name of County Board Service and Support Administrator (SSA)

County Board Service SSA's phone number

Optional Medicare Demographic Information

Medicare PIN number

DMERC number

Enter any Ohio Medicaid 7-digit Group Provider Numbers you are Affiliated with

Please enter the number

No group numbers have been added.

Enter all languages you speak/write.

Language Effective Date End Date

-- Language Selection --

Language	Effective Date	End Date
ENGLISH		

- The Related Party Tab is where you will list whether your CEO has any employment history with another DODD certified agency. Also, you will list any related parties (Family Members to the CEO) who are/were providers.

Start	Demographic	Relative / Associate	Medicaid Fee	Service	County of Business	NPI	Disclosure (Page 1 of 2)	Disclosure (Page 2 of 2)	Medicaid Provider Agreement	Download Files	Documents Required	Summary	Confirmation
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Employment

Are or have you ever been an employer or employee at an agency serving individuals with developmental disabilities?

Please select one

No, our CEO does not have employment history at another DODD certified agency.

Yes, our CEO does have employment history at another DODD certified agency.

Related Parties

Does your agency's CEO have a family member who provides or has provided services for DODD to a developmentally disabled person? "Relative" applies to your agency's CEO or his or her current or former spouse.

Please select one

No, our CEO does not have a relative who is/was certified.

Yes, our CEO does have a relative who is/was certified.

First Name Middle Initial

Last Name

Relationship

Business Associates

Please refer to this list of business associates. Indicate if any of your business associates are or were certified to provide services through the Ohio Department of Developmental Disabilities(DODD).

Please select one

No, our CEO does not have a business associate who is/was certified.

Yes, our CEO does have a business associate who is/was certified.

First Name Middle Initial

Last Name

Association

- The Medicaid Fee Tab is where you will list any Medicaid Numbers you may have through the Department of Medicaid. If you do not have a Medicaid Number please save and continue.

[Home](#) Application ID: 64621

Start	Demographic	Relative / Associate	Medicaid Fee	Service	County of Business	NPI	Disclosure (Page 1 of 2)	Disclosure (Page 2 of 2)	Medicaid Provider Agreement	Download Files	Documents Required	Summary	Confirmation
Completed	Completed	Completed	Pending	Pending	Pending	Completed	Pending	Pending	Pending	Completed	Pending	Pending	FINISH

The following fee is being assessed for the first time application and acquisition of a Medicaid Provider Identification number (MPI) should your application for certification under the IO/LV1/SELF and/or TDD waivers be approved. Please, note this fee is sent to the Ohio Department of Medicaid (ODM) per Ohio Administrative Code 5101:3-1-17.8, Medicaid Provider Screening and Application Fees. This fee is not your DODD application fee, and is entirely separate though it is being collected at the same time. DODD application fees are collected under authority of Ohio Administrative Code 5123:2-2-01. If your application is denied, the Medicaid application fee will be refunded. However, the DODD application fee is non-refundable.

Do you have a current Medicaid Provider Identification Number (MPI) assigned by the Ohio Department of Medicaid (ODM was formerly part of the Ohio Department of Job and Family Services.), for the certification of Waiver Services?

Yes, I have a current and active Medicaid Provider Identification Number (MPI) with ODM for Wavier Contract(s).
 No, I don't have a current and active Medicaid Provider Identification Number (MPI) with ODM for Wavier Contract(s).

- The Service Tab is where you will select the service(s) you would like to provide. If you click the question mark beside the service name, you will get a description of the service in the box on the left side of the screen.

[Home](#) ODM Fees: \$554.00 Total Application Fees: \$554.00 Application ID: 64621

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Applications for provider certification (except for the following HCBS waiver services which are not subject to an application fee: Adaptive and Assistive Equipment, Environmental Accessibility Adaptations, Functional Behavioral Assessment, Nutritional Services, Home Delivered Meals, Interpreter, Support Brokerage (Unpaid), Personal Emergency System, Specialized Medical Equipment and Supplies, Social Work, CTI - Clinical/Therapeutic Interventionist, CTI - Specialized Clinical/Therapeutic Interventionist, CTI - Senior-Level Clinical/Therapeutic Interventionist, HPC Transportation-Commercial, Non-Medical Transportation-Commercial, Integrated Employment - Coworker, Participant/Family Stability Assistance - Training, Remote Monitoring Equipment, Participant/Family Stability Assistance - Counseling, Community Inclusion - Commercial Vehicle, Support Brokerage (Paid), Adult Day Health Center, TDD Home Delivered Meals, TDD Home Modifications, Out-of-Home Respite, TDD Supplemental Adaptive and Assistive Devices, TDD Personal Emergency Response, Supplemental Transportation, Personal Care Aide, Personal Care Aide CSTO) must include the appropriate application fee. Payment in full is required at the time of application. Applications submitted without payment will not be processed.

Service Selection (Please select the services below in which you would like to be certified)

Service Name	
Adaptive and Assistive Equipment	<input type="checkbox"/>
Adult Day Health Center(TDD waiver Only)	<input type="checkbox"/>
Adult Day Support	<input checked="" type="checkbox"/>
Adult Family Living	<input checked="" type="checkbox"/>
Adult Foster Care	<input type="checkbox"/>
Community Inclusion--Commercial Vehicle(SELF waiver Only)	<input type="checkbox"/>
Community Inclusion--Personal Assistance(SELF waiver Only)	<input type="checkbox"/>
Community Inclusion--Transportation(SELF waiver Only)	<input type="checkbox"/>
Non-Medical Transportation (Commercial) - Trip	<input type="checkbox"/>
Nutritional Services	<input type="checkbox"/>
Out-of-home Respite(TDD waiver Only)	<input type="checkbox"/>
Participant/Family Stability Assistance--Counseling (SELF waiver Only)	<input type="checkbox"/>
Participant/Family Stability Assistance--Training (SELF waiver Only)	<input type="checkbox"/>
Personal Care Aide(TDD waiver Only)	<input type="checkbox"/>
Personal Emergency System	<input type="checkbox"/>
Remote Monitoring	<input type="checkbox"/>

Click on a question mark (?) to read descriptions of the services.

- The County of Service Tab is where you can make changes to the counties in which your business operates.

[Home](#) Application Fees: \$800.00 ODM Fees: \$554.00 Total Application Fees: \$1,354.00 Application ID: 64621

Start	Demographic	Relative / Associate	Medicaid Fee	Service	County of Business	NPI	Disclosure (Page 1 of 2)	Disclosure (Page 2 of 2)	Medicaid Provider Agreement	Attestation	Download Files	Documents Required	Summary	Confirmation
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Providers are certified statewide. We would like to identify the counties that your business operates in (even if you are not accepting new Individuals in those counties).

We would also like for you to identify the counties that you are accepting new Individuals in. This information will be published to our website to help you attract new business.

You will be able to log into our website to update these at any time.

Selected Service-County (By default, a service is certified for the county of your physical address)

	Certified Service	My business operates in the following counties	My business is currently accepting new Individuals in the following counties
Edit	Adult Day Support	Franklin	Franklin
Edit	Adult Family Living	Franklin	Franklin
Edit	Homemaker Personal Care	Franklin	Franklin
Edit	HPC Transportation	Franklin	Franklin

Click 'Edit' to Add or Remove Service Counties

- The National Provider Identifier (NPI) Tab is required if you are provider DD Nursing services. If you are not provider DD Nursing, you may Save and Continue.

[Home](#) Application Fees: \$800.00 ODM Fees: \$554.00 Total Application Fees: \$1,354.00 Application ID: 64621

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National Provider Identifier

If you have received your National Provider Identifier (NPI) number, please report it here

If you had a previous NPI number, please report it here

[Please follow this link for more information about National Provider Identifiers](#)

- On the Disclosure Tab 1, you will find a list of questions.

[Home](#) Application Fees: \$800.00 ODM Fees: \$554.00 Total Application Fees: \$1,354.00 Application ID: 64621

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Question 1

Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organization, agency, or practice that have been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

Yes No

Name: Offense: Date: SSN/EIN:

Question 2

Are there any directors, officers, agents, or managing employees of the institution, agency, organization, or practice who have ever been indicted or convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

Yes No

Name: Offense: Date: SSN/EIN:

- Continuing on the first Disclosure Tab. For question 3, you will be asked to list ownership information. The CEO will always be required, because even if they have no ownership in the Agency, they are considered an **Indirect Owner**. Please list any other individuals who have an ownership stake with the Agency, whether direct or indirect ownership.

Disclosure and
Ownership/Control Interest
Statement
This information is
REQUIRED of all providers.

Question 3

List the information for individuals and organizations having direct or indirect ownership or a controlling interest in the entity or practice.

Yes No

Title: * Affiliation Type: *

Owner Business Name:

Owner First Name: * Middle Name: Last Name: *

Contact First Name: * Middle Name: Last Name: *

Address 1: * (P.O. and Drop Boxes are not acceptable)

Address 2:

City: * State: * Zip Code: * -

County: *

Phone Number: *

Fax Number:

Owner SSN/EIN: * Owner Date of Birth: *

Owner Effective Date: * Owner End Date: * Owner % Owned: *

Please enter detailed information and click "ADD" to save it.

Question 4

- On the Disclosure Tab 2, you will answer the additional questions before proceeding.

[Home](#) Application Fees: \$800.00 ODM Fees: \$554.00 Total Application Fees: \$1,354.00 Application ID: 64621

Start	Demographic	Relative / Associate	Medicaid Fee	Service	County of Business	NPI	Disclosure (Page 1 of 2)	Disclosure (Page 2 of 2)	Medicaid Provider Agreement	Attestation	Download Files	Documents Required	Summary	Confirmation
Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Pending	Pending	Completed	Pending	Pending	FINISH

Disclosure and Ownership/Control Interest Statement
This information is **REQUIRED** of all providers.

Question 7
Do you anticipate any change in ownership or control within the year?

Yes No

Date:

Explanation:

Question 8
Is this entity operated by a management company, or leased in whole or part by another organization?

Yes No

Date:

Explanation:

Question 9
Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?

Yes No

Question 10
Is this entity chain affiliated? (If yes, list name, address of Corporation, and EIN number.)

Yes No

[Home](#) Application Fees: \$800.00 ODM Fees: \$554.00 Total Application Fees: \$1,354.00 Application ID: 64621

Start	Demographic	Relative / Associate	Medicaid Fee	Service	County of Business	NPI	Disclosure (Page 1 of 2)	Disclosure (Page 2 of 2)	Medicaid Provider Agreement	Attestation	Download Files	Documents Required	Summary	Confirmation
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This provider agreement is a contract between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the Provider agrees to comply with the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies to:

1. Render medical assistance services as medically necessary for the patient and only in the amount required by the patient without regard to race, color, age, gender, sexual orientation, marital status, national origin, ancestry, religion, disability or source(s) of payment; submit claims only for services actually performed, and bill the Department for no more than the usual and customary fee charged other patients for the same service.
2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Department. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in Chapter 5160 of the Administrative Code.
3. Accept the allowable reimbursement for all covered services as payment-in-full and, except as required in paragraph 2 above, will not seek reimbursement for that service from the patient, any member of the family, or any other person.
4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer.
5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Ohio Medicaid Fraud Control unit or their designees any information maintained under paragraph 4 above for audit or review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of Medicaid payments and may result in termination from the Medicaid program.

I accept the terms and conditions contained in paragraphs 1 through 16 above.

Type your full name as your Electronic Signature. Please note, the name must match one of the names listed as a direct/indirect owner in the Disclosures.

Agreement

I accept the terms and conditions

[Electronic Agreement Signature Saved](#)

- The Medicaid Provider Agreement requires an electronic signature. The signature must match the name that was listed on the Demographic Tab.

- The Attestation Tab will require your initials in two areas. You do have the ability to print out the attestations. It is advised that you read over this document.

[Home](#) Application Fees: \$800.00 ODM Fees: \$554.00 Total Application Fees: \$1,354.00 Application ID: 64621

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Each independent provider; each CEO of an agency provider; and each employee, contractor, and employee of a contractor of an agency provider who is engaged in a direct services position must meet the following requirements. By initializing this page, you indicate your understanding and assurance to comply with the following requirements.

1. Provider acknowledges the ongoing responsibility to coordinate with designated persons and family members, where appropriate, to ensure the provision of coordination of services.
2. Provider shall ensure the services take place in a non-residential setting separate from any home or facility in which the individuals resides.
3. Provider will recognize, report to SSA and record changes in behaviors, as well as safety and sanitations hazards.
4. Provider will document all services provided to and on behalf of the individual in accordance with rule 5123:2-9-05 of Ohio Administrative Code and Appendix E to rule 5123:2-9-19 of the Ohio Administrative Code.
5. Provider will meet all federal, state, and local requirements pertaining to the physical environment (building and grounds) where the adult day support and/or vocational hab services are provided.
6. Provider agrees to provide habilitation management.
7. Adult day support and/or Vocational Habilitation shall be provided by an agency provider that meets the requirements of Administrative Rule 5123:2-9-17 and that has a medicaid provider agreement

[View Printer Friendly Version](#)

All providers must read the statements below, and sign their initials

In accordance with Executive Order 2011-03K, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2011-03K, (2) has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Executive Order 2011-03K is, in itself, grounds for termination of this contract or grant and may result in the loss of other contracts or grants with the State of Ohio.

A copy of Executive Order 2011-03K can be found at: <http://www.governor.ohio.gov/Portals/0/pdf/executiveOrders/EO2011-03.pdf>

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, knowinlv and willfullv failina to fully and

- Here is where you initial. Be sure to click “Agree” after each initial.

Agreement

If you have questions about any of the items that you need to attest to, please contact 1 (800) 617-6733 or email provider services at Provider.Certification@dodd.ohio.gov.

JL Applicant Initials

You have successfully clicked the Agree button and completed your attestations.

Rapback

Pursuant to Administrative Code 5123:2-2-01, Providers must "consent to be enrolled in the Ohio attorney general's retained applicant fingerprint database ('Rapback')." Rapback is a criminal background check system. By initialing this consent and submitting your application, you are consenting to Rapback enrollment as part of your application processing.

I consent to enrollment by the Ohio Department of Developmental Disabilities in the Ohio attorney general's retained applicant fingerprint database (Rapback).

JL CEO Initials

You have successfully Agreed.

- The Download Files Tab includes required documents that will need to be downloaded, printed and signed.

[Home](#) Application Fees: \$800.00 ODM Fees: \$554.00 Total Application Fees: \$1,354.00 Application ID: 64621

Start	Demographic	Relative / Associate	Medicaid Fee	Service	County of Business	NPI	Disclosure (Page 1 of 2)	Disclosure (Page 2 of 2)	Medicaid Provider Agreement	Attestation	Download Files	Documents Required	Summary	Confirmation
Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Pending	Pending	FINISH

These documents are required in order to be an Ohio Medicaid Provider, and you cannot become certified until you have submitted these documents to the department. You must download the documents here, to be signed, dated, and uploaded on the 'Documents Required' tab (along with your other documentation).

Documents

- [Nondisclosure Statement.pdf](#)
- [Request for Taxpayer Identification Number and Certification W9 rev012011.pdf](#)
- [Vendor Information Form OBM5657 11152013.pdf](#)

A PDF Reader is required to read these pdf files. If you don't have it already, you can get it here...
 

- The Documents Required Tab is used to upload all the required documents except for the BCI and the FBI. Those two documents will need to be sent directly to DODD from the BCI office.

Please be advised that new services are available for selection on the Services Screen.

[Home](#)
Application Fees: \$75.00 Application ID: 64688 MBS Contract Number: 3109737 Oaks Contract Number: 0000153615

Start	Demographic	Relative / Associate	Service	County of Business	NPI	Disclosure (Page 1 of 2)	Disclosure (Page 2 of 2)	Medicaid Provider Agreement	Attestation	Download Files	Documents Required	Summary	Confirmation
Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	FINISH

These documents are required in order to be an Ohio Medicaid Provider, and you cannot become certified until you have submitted these documents to the department. You must scan and upload the documents here to proceed with submitting your application.

***BCII Background Checks cannot be uploaded to the Department. They must be mailed directly from the BCII office to the Ohio Department of Developmental Disabilities. This process can take up to 30 days, so please allow enough time for the Department to receive the document. When requesting your BCII, please use the following code for your reason fingerprinted:
BCII Code: 5123.169***

Please have your BCII sent to the following address (only BCII's will be accepted through the mail):

***The Ohio Department of Developmental Disabilities
Attention Provider Certification
30 E. Broad Street
13th Floor
Columbus, Ohio 43215***

Required Documents
Please, ensure that all Required Documents have a corresponding Document Upload except the BCII and FBI, as listed.

Choose File to Upload:

- Documents can be uploaded individually or in a group. Please remember to make sure you upload the correct documents, as incorrect or missing documents could delay the review process. A check mark will need to be placed on the document(s) you want to upload. You will then select the Browse button. Locate the files on your computer, select so that the file appears in the “Choose File to Upload” box. Press Upload.

Required Documents

<input checked="" type="checkbox"/> <i>Bachelors Degree</i>	<input checked="" type="checkbox"/> <i>Policies and procedures for ADS</i>
<input type="checkbox"/> <i>BCII Background Check</i>	<input checked="" type="checkbox"/> <i>Policies and procedures on Drivers</i>
<input checked="" type="checkbox"/> <i>BWC Verification</i>	<input checked="" type="checkbox"/> <i>Proof of Age</i>
<input checked="" type="checkbox"/> <i>Completed W-9 Form</i>	<input checked="" type="checkbox"/> <i>Proof of Ohio Residency</i>
<input type="checkbox"/> <i>FBI Background Check</i>	<input checked="" type="checkbox"/> <i>Proof of Staffing</i>
<input checked="" type="checkbox"/> <i>High School Diploma/GED</i>	<input checked="" type="checkbox"/> <i>Secretary of State Certificate</i>
<input checked="" type="checkbox"/> <i>Initial Overview</i>	<input checked="" type="checkbox"/> <i>Social Security Number</i>
<input checked="" type="checkbox"/> <i>Liability Insurance</i>	<input checked="" type="checkbox"/> <i>State of Ohio Identification</i>
<input checked="" type="checkbox"/> <i>Management Policies and Procedures</i>	<input checked="" type="checkbox"/> <i>Tax ID Verification Letter</i>
<input checked="" type="checkbox"/> <i>Non-Disclosure Agreement</i>	<input checked="" type="checkbox"/> <i>Unemployment Compensation Verification</i>
<input checked="" type="checkbox"/> <i>One year of Full-Time, Paid Work</i>	<input checked="" type="checkbox"/> <i>Vendor Information Form</i>

Choose File to Upload:

- The document(s) should appear in the box below. You do have the ability to print out the attestations. It is advised that you read over this document.

\\doddvdifs01\desktop\jovon.loveless\Desktop\UAT Folder\UAT Test document 1.docx has been uploaded

Documents Uploaded

		FileName	Requirement
Delete	View	64621_Attestations.html	Attest
Delete	View	UAT Test document 1.docx	BADegree, BWC, W9form, Diploma, INIOV, LIABINS, Manage, NonDis, CEOResume, PolcADS, PolcDriver, ProofOfAge, OHRes, STAFFPROF, SOSCert, SSN, StateID, TaxIDLtr, UNEMPLCOM, VendInfo

Previous Save and Continue

- The Summary Tab list a summary of the documents you may have uploaded and the date your attestation was signed.

[Home](#) Application Fees: \$800.00 ODM Fees: \$554.00 Total Application Fees: \$1,354.00 Application ID: 64621

Start	Demographic	Relative / Associate	Medicaid Fee	Service	County of Business	NPI	Disclosure (Page 1 of 2)	Disclosure (Page 2 of 2)	Medicaid Provider Agreement	Attestation	Download Files	Documents Required	Summary	Confirmation
Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	FINISH

Your Certification Type is: **Agency**
 Your Application Type is: **Initial Certification (3 years)**
 Your Application ID is: **64621**

Application Summary (Do not change your email address. We will not be able to contact you.)

Demographic Information

Entity Type:	Limited Liability Company	Service Type:	Waiver
Agency Name:	Happy Home	Email:	jovon.loveless@dodd.ohio.gov
SSN/TIN:	12-3122332	Phone:	(614) 223-3232
CEO Date Of Birth:	11/26/1964	CEO SSN:	***-**-1321
Lived Outside Ohio:	No		
CEO Name:	Love, James J.		
Secondary Contact:	Love, Mary T. MaryLove@gmail.com		

Address Information

- The Confirmation Tab displays the DODD and ODM application fees. You have the ability to pay with Electronic Check or Credit Card. If needed, County Boards can contact Provider Certification for payment options/procedures.

[Home](#) Application Fees: \$800.00 ODM Fees: \$554.00 Total Application Fees: \$1,354.00 Application ID: 64621

Start	Demographic	Relative / Associate	Medicaid Fee	Service	County of Business	NPI	Disclosure (Page 1 of 2)	Disclosure (Page 2 of 2)	Medicaid Provider Agreement	Attestation	Download Files	Documents Required	Summary	Confirmation
Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	FINISH

Payment Information

Payment On Behalf Of: Happy Home
Agency Name: Happy Home
Application Type: Initial Certification (3 years)
Provider Type: Small Agency

DODD Application Fees: 800.00

ODM Application Fees: \$554.00

Total Application Fees: \$1,354.00

Payment Due

Payment Selection

Payment Method:

- Once the application fee is paid, your DODD Ticket ID will be displayed. You can use this, as well as your application ID (located at the top of the page), when contacting DODD to check on your application.

[Home](#) Application Fees: \$800.00 ODM Fees: \$554.00 Total Application Fees: \$1,354.00 Application ID: 64621

Start	Demographic	Relative / Associate	Medicaid Fee	Service	County of Business	NPI	Disclosure (Page 1 of 2)	Disclosure (Page 2 of 2)	Medicaid Provider Agreement	Attestation	Download Files	Documents Required	Summary	Confirmation
Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	FINISH

Application Submission Status

Thank you for submitting your application requesting provider certification through the Ohio Department of Developmental Disabilities. Your application will be sent to a provider certification specialist for review. You will receive an email from the Provider Certification group indicating if we are missing any documentation and the status of your application. If you have questions or concerns, please contact the DODD Support Center at **1-800-617-6733, option 3**, and reference ticket number below.

Your DODD Ticket ID:
#28412

Please reference this number when communicating with and/or submitting documents to the DODD.

You should [print this page](#) for your records.

Payment Information

Agency Name:	Happy Home
Application Type:	Initial Certification (3 years)
Provider Type:	Small Agency
Payment On Behalf Of:	Happy Home
Payment Type:	Override
Payment Amount:	\$1,354.00
Payment Note:	Test

Your payment was accepted.
 Acceptance of your payment does not mean that you are guaranteed to be certified.

[Click here to return to the DODD Home Page](#)

