



Entity Completing Form:	<input type="checkbox"/> Provider
	<input type="checkbox"/> Administrative Entity (AE)

☐ New Provider
Initial Qualification

☐ Existing Provider
Re-Qualification

☐ Update
to Add/Remove Specialty

SECTION 1 - PROVIDER INFORMATION

PROVIDER NAME:		MPI #:
LAST NAME:	FIRST NAME:	TITLE:
PHONE NUMBER:		EMAIL ADDRESS:
STREET ADDRESS:		CITY, STATE, ZIP CODE:
ASSIGNED AE:		DATE SUBMITTED:

SECTION 2 - PROVIDER ATTESTATIONS

<input type="checkbox"/> Yes <input type="checkbox"/> No	The organization assures that it will provide and/or participate in training specific to the services provided and to the needs of the individuals served.
<input type="checkbox"/> Yes <input type="checkbox"/> No	The organization assures that it will train all staff (direct, contracted, or in a consulting capacity) to meet the unique needs of the participant which includes but is not limited to communication, mobility, and behavioral needs.
<input type="checkbox"/> Yes <input type="checkbox"/> No	The organization assures that it will complete necessary pre in-service training based on the ISP for all staff prior to spending any time alone with a participant.
<input type="checkbox"/> Yes <input type="checkbox"/> No	The organization assures that it will carry & maintain adequate insurance to satisfy the requirements applicable to the services you intend to provide, as stipulated in the Consolidated, Community Living, and P/FDS waivers. This includes Worker's Compensation Insurance, Commercial General Liability Insurance, and Automobile Insurance.
<input type="checkbox"/> Yes <input type="checkbox"/> No	The organization assures that it will carry out the person's Individual Support Plan.
<input type="checkbox"/> Yes <input type="checkbox"/> No	The organization assures that it will comply with ODPs Incident Management Policy.
<input type="checkbox"/> Yes <input type="checkbox"/> No	The organization attests that they will comply with applicable statutes and regulations.
<input type="checkbox"/> Yes <input type="checkbox"/> No	The organization assures that it will certify that all employees who drive as part of their work duties possess a current driver's license.
<input type="checkbox"/> Yes <input type="checkbox"/> No	The organization assures that it will certify that all vehicles used for work duties have valid vehicle registration, current inspection, PUC license (if applicable), and insurance for the vehicle used to provide the transportation services.
<input type="checkbox"/> Yes <input type="checkbox"/> No	The organization attests that they will consistently maintain all ODP Waiver qualification requirements on an ongoing basis and maintain documentation as outlined in the ODP Provider Qualification Documentation Record.

The typing of Provider CEO name below indicates that the organization attests to the accuracy of the responses above.

Name of Provider CEO:

Date:

[illegible]



SECTION 3 - QUALIFICATION DETERMINATION OF SERVICES (CONTINUED)

OVERALL COMMENTS



SECTION 4 - ADMINISTRATIVE ENTITY VERIFICATION OF QUALIFICATION

<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the provider complete and submit the ODP Provider Qualification Documentation Record information for each specialty they intend to provide?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the provider submit all required documentation for each specialty they intend to provide?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the provider complete Section 2, Provider Attestations affirmatively?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the provider submit provider applicant orientation certificate of completion?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the provider successfully complete the New Provider Self-Assessment?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the provider successfully complete the Provider Contact form?

The typing of AE Representative name below indicates that AE attests to the accuracy of the responses above.

AE Representative Name & Title:	Verifying Date: MM DD YYYY
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- **NEW PROVIDERS:** Must requalify by the end of the following fiscal year after enrolling first site.
- **EXISTING PROVIDERS:** Must requalify on a three-year cycle based upon the last digit of the provider's MPI number.