pennsylvania
DEPARTMENT OF HUMAN SERVICES

ODP Provider Qualification Form

Entity Completing Form: ☐ Provider ☐ 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: --CHOOSE ONE--
PHONE NUMBER:	EMAIL ADDRESS:	
STREET ADDRESS:	CITY, STATE, ZIP CODE:	
ASSIGNED AE: --CHOOSE ONE--	DATE SUBMITTED:	

SECTION 2 - PROVIDER ATTESTATIONS

☐ Yes ☐ 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.
☐ Yes ☐ 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.
☐ Yes ☐ 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.
☐ Yes ☐ 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.
☐ Yes ☐ No	The organization assures that it will carry out the person's Individual Support Plan.
☐ Yes ☐ No	The organization assures that it will comply with ODPs Incident Management Policy.
☐ Yes ☐ No	The organization attests that they will comply with applicable statutes and regulations.
☐ Yes ☐ 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.
☐ Yes ☐ 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.
☐ Yes ☐ 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:

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SECTION 3 - QUALIFICATION DETERMINATION OF SERVICES

Provider to Complete			AE to Complete		
PROVIDER TYPE	SPECIALTY	ENHANCED LEVEL	QUALIFICATION DETERMINATION	DATE OF DETERMINATION	COMMENTS
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		

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SECTION 3 - QUALIFICATION DETERMINATION OF SERVICES (CONTINUED)

Provider to Complete			AE to Complete		
PROVIDER TYPE	SPECIALTY	ENHANCED LEVEL	QUALIFICATION DETERMINATION	DATE OF DETERMINATION	COMMENTS
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		
--Choose a Provider Type--	--Choose a Specialty--	☐ Yes ☐ No	☐ Qualified ☐ Not Qualified		

OVERALL COMMENTS

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SECTION 4 - ADMINISTRATIVE ENTITY VERIFICATION OF QUALIFICATION	
☐ Yes ☐ No	Did the provider complete and submit the ODP Provider Qualification Documentation Record information for each specialty they intend to provide?
☐ Yes ☐ No	Did the provider submit all required documentation for each specialty they intend to provide?
☐ Yes ☐ No	Did the provider complete Section 2, Provider Attestations affirmatively?
☐ Yes ☐ No	Did the provider submit provider applicant orientation certificate of completion?
☐ Yes ☐ No	Did the provider successfully complete the New Provider Self-Assessment?
☐ Yes ☐ 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

- **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.