Department of Health and Human Services

Application/Letter of Intent/ Renewal Application

Home and Communtiy Based Specialized Provider Certification

NEBRASKA
Good Life. Great Mission.

Applications should be submitted electronically to:
Provider Relations
DHHS—Division of Developmental Disabilities
DHHS.DDDCommunityBasedServices@nebraska.gov

Renewal Applications should be submitted electronically to: DHHS.CBSCert@nebraska.gov

IDENTIFYING INFORMATION:

1. Full Name of Entity to be Certified: *(Business Name or Legal Name of Individual)*

2. Legal Name of Entity to be Certified: *(If different from above)*

3. Federal Employer ID #: *(Required if not an Individual)*

4. Business Address:
   Street Address:
   City:_____ State: _____ Zip: _____
   Phone:_____ Fax: _____ Email: _____

5. Preferred Business Mailing Address: *(If different than above)*
   Street Address:
   City: _____ State: _____ Zip: _____
   Phone:_____ Fax: _____ Email: _____

6. Director Information:
   Director Name: _____ Director Date of Birth: _____
   Street Address: _____
   City: _____ State: _____ Zip: _____
   Phone:_____ Fax: _____ Email: _____

OWNERSHIP INFORMATION:

1. Ownership Type (*select one*):
   ☐ Individual/Sole Proprietorship
   ☐ Partnership

☐ Corporation
☐ Government
☐ Limited Liability Company
☐ Other: *(please specify)*

2. Owner(s) information:
   Owner Name: _____ Owner Date of Birth: _____
   Mailing Address: _____
   City: _____ State: _____ Zip: _____
   Phone: _____ Fax: _____ Email: _____

   Owner Name: _____ Owner Date of Birth: _____
   Mailing Address: _____
   City: _____ State: _____ Zip: _____
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   Mailing Address: _____
   City: _____ State: _____ Zip: _____
   Phone: _____ Fax: _____ Email: _____

3. Profit Status:
   ☐ Non-Profit ☐ For Profit

4. Registration with Nebraska Secretary of State's Office: *(All businesses must be registered with the Nebraska Secretary of State prior to certification. Please see: https://www.nebraska.gov/osbr/index.cgi)*
   ☐ Yes ☐ No

5. Foreign Corporation: *(If yes, please attach a copy of the registration as a foreign corporation filed with the Nebraska Secretary of State)*
   ☐ Yes ☐ No

6. Controlling Entities: *(List all additional owners not listed above, partners, limited liability corporation members, members of boards of directors/managing operations, and any other persons with financial interests or investments in the agency. In the case of publically held corporations, only those stockholders who own 5% or more of the company's stock must be listed).*

Name	Address	City, State, Zip

7. Governing Board or Advisory Committee Members: *(See Nebraska Revised Statutes §83-1217 for additional information.)*

Name	Role *(e.g. Family Member)*

a.) **Will any of these persons provide direct support services (either regularly or in an emergency?)**

☐ **Yes** ☐ **No**

b.) **If the answer to (a) is "Yes", is/are the person(s) certified or licensed as a member of their profession in Nebraska?**

☐ **Yes** ☐ **No**

If the answer to (b) is a "Yes", please submit a copy of the current license or certification with this application or specify your profession and send your license or certification number.

PROGRAM DESCRIPTION FOR PROVISION OF SERVICES: *(Developmental Disabilities services are provided under two separate Medicaid HCBS Waivers, the DD Adult Day waiver (DDAD) and the Comprehensive Developmental Disabilities waiver (CDD). Please see DD Policy Manual for more information.)*

1. Service Options to be provided: (*Check all that apply. Services marked with an asterisk [*] have additional requirements. Please see DD Policy Manual for more details.*)

DDAD	CDD	Direct Participant Service	Habilitative	Service Code
☐	☐	Adult Day Services	No	6221
NA	☐	Behavioral In-Home Habilitation	Yes	1796
NA	☐	Child Day Habilitation	Yes	6396
☐	☐	Consultative Assessment Services*	Yes	7783
☐	☐	Continuous Home—Residential Habilitation	Yes	3992
☐	☐	Small Group Vocational Support	Yes	8338
☐	☐	Community Integration	Yes	9845
☐	☐	Community Integration—Remote	Yes	5913
☐	☐	Day Supports	Yes	8652
☐	☐	Day Supports—Remote	Yes	9828
☐	☐	Homemaker	No	9769
NA	☐	Hospital Support	Yes	5220
NA	☐	Host Home—Residential Habilitation	Yes	9293
☐	☐	Independent Living	Yes	8362
☐	☐	Independent Living—Remote	Yes	6722
NA	☐	Medical In-Home Habilitation	Yes	9220
☐	☐	Prevocational Services	Yes	8362
☐	☐	Respite Care—Agency	No	2656
NA	☐	Shared Living—Residential Habilitation	Yes	1472
☐	☐	Supported Employment—Follow Along	Yes	2141
☐	☐	Supported Employment—Follow Along—Remote	Yes	1666
☐	☐	Supported Employment—Individual	Yes	9695
☐	☐	Supported Employment—Individual—Remote	Yes	6435
☐	☐	Supported Family Living	Yes	7494

☐	☐	Supported Family Living—Remote	Yes	6168
☐	☐	Transitional Services	No	7835
☐	☐	Transportation	No	3764

DDAD	CDD	Other Service*	Habilitative	Service Code
☐	☐	Assistive Technology*	No	9418
☐	☐	Environmental Modification Assessment*	No	2633
☐	☐	Home Modifications*	No	1398
☐	☐	Personal Emergency Response System (PERS)*	No	3447
NA	☐	Therapeutic Residential Habilitation*	Yes	7286
☐	☐	Vehicle Modifications*	No	6995

2. Service Delivery Locations: *(If exact address is unknown, please list the city or county in which services will be provided.)*

Service Type	Physical Address	City, State, Zip	Capacity

3. List of Existing and Proposed Contractors: *(Contracts are limited to Shared Living, Supervision of Medication Aides, transportation services, janitorial services, etc. No habilitative waiver services other than Shared Living may be provided by contractors.)*

Contracted Service	Contractor Name	Purpose of Contract

CRIMINAL HISTORY DISCLOSURE: *(per Title 404 NAC 4-002.05A(16), list any criminal history, or listing on the Department's Registries, or the Nebraska State Patrol Sex Offender Registry must be disclosed as a part of the application process)*

1. List all criminal history for any Owner, Director, or Manager of the entity. Please attach additional sheets as needed.

Name	Role *(e.g. Owner)*	Date of Birth	Description of Criminal History

ATTACHMENTS:

1. Required:

   ☐ A copy of the applicant's organizational chart identifying authority over the agency and the organization of management positions.

   ☐ A completed electronic copy of the Policy and Procedure Worksheet for Prospective Providers.

   ☐ An electronic copy of current policies and procedures, as specified in 404 NAC 4-002.03. These policies should be paginated, as well as tabulated or marked to identify the location of each regulatory requirement.

2. If needed:

   ☐ If the applicant is a foreign corporation, a copy of the registration as a foreign corporation filed with the Nebraska Secretary of State

   ☐ Additional pages outlining additional Controlling Entities, Governing Board or Advisory Committee Members, Service Delivery Locations, Existing and Proposed Contractors, or Criminal History.

UNDERSTANDINGS AND ATTESTATIONS:

1. I understand that the Department will not certify a provider whose administrative staff or management have been convicted of any of the crimes listed in 404 NAC 4-003.02.

2. I, the undersigned, attest that all assurances given in this application are to be considered accurate for the certification period unless changes are submitted in writing, as specified in 404 NAC 4-001.01A.

3. I, the undersigned, attest that I have read the rules and regulations issued by the Nebraska Department of Health and Human Services and will comply with them should a certification be issued.

4. I understand that failure to disclose requested information on the application, or providing incomplete or incorrect information on the application, may result in the denial of a certification, as specified in 404 NAC 4-001.01D.

Signature of Director: *(typed)* _____ Date: _____

Signature of Governing Authority Chairperson: *(if applicable, typed)*

_____ Date: _____