Appendix FF – Notice of Intent to Become a EDWP (CCSP and SOURCE) Service Provider

INSTRUCTIONS: (Complete Parts I – IV.)

1. Please complete each item of this *Notice of Intent to Become a EDWP (CCSP AND SOURCE) Service Provider*. Refer to *Part I – Policies and Procedures for Medicaid/PeachCare for Kids, Part II – Policies and Procedures for* EDWP (CCSP/SOURCE) *Services Program* Section 601.2 and each applicable EDWP (CCSP and SOURCE) service-specific manual.
2. Submit the completed form to ccsp.messages@dch.ga.gov after completing an online application to become a EDWP (CCSP and SOURCE) provider during the open enrollment cycles of March 1st – March 31st or September 1st – September 30th.

***Do NOT mail documents to the Department

APPLICATION TRACKING NUMBER (ATN) for your online application: **CCSP (590) ATN: _____**
SOURCE (930) ATN: _____

PART I – AGENCY INFORMATION

1. Legal name of agency/applicant organization:

   _____

   NOTE: If the agency is regulated by the Department of Community Health, Healthcare Facility Regulation Division (HFRD), the applicant's governing body and agency/facility name **must be identical** to the name(s) listed on the permit issued by the HFRD, as well as, all other documents submitted in your packet.

2. Mailing Address: _____

   _____

   _____

3. County of Mailing Address: _____

4. Street Address/Physical Location: _____

   _____

   _____

5. County of Street Address/Physical Location: _____

6. Business Telephone: _____

7. Fax Number: _____

8. After-Hours Number: _____

9. Business Electronic Mail Address (e.g., username@bellsouth.net):

   _____

10. Contact Person, Title, and Telephone:

    _____

PART II– SERVICE FOR WHICH APPLYING

11. Indicate the service for which application is being made.

- ☐ Adult Day Health (ADH)
- ☐ Alternative Living Services (ALS) – Family
- ☐ Alternative Living Services (ALS) – Group
- ☐ Emergency Response Services
- ☐ Skilled Nursing Services
- ☐ Case Management
- ☐ Home Delivered Meals*
- ☐ Home Delivered Services**
- ☐ Out-of-Home Respite Care
- ☐ Personal Support Services
- ☐ Structured Family Care

NOTE: Initial applications (Providers without previous EDWP experience) are limited to one service at time of application, Example- Adult Day Health or Alternative Living Service etc. No combination of services for initial applications except PSS/X and SNS.

*Please submit current Title III status with the Area Agency on Aging, current monitoring results, and a letter from the Area Agency on Aging on letterhead stating that the applying agency is in good standing.

**Submit the Home Health Medicaid Number: _____

PART III – ENROLLMENT INFORMATION

12. Is this a "buyout" or change of ownership?
☐ Yes ☐ No

If "yes", list the name and EDWP (CCSP and SOURCE) Medicaid Provider Number of the previous owner/provider agency: _____

_____

_____

13. Is the applicant currently enrolled in the EDWP (CCSP and SOURCE) or any other waiver program or state plan service? ☐ Yes ☐ No

If "yes", list the service, Medicaid Provider Number, and date of enrollment for each service:

Other Waiver or State Plan Service	Medicaid Provider Number	Date of Enrollment

14. Place a check (√) beside the county(ies) in which the EDWP (CCSP and SOURCE) service will be provided. **NOTE: Up to or ten (10) counties may be requested, but keep in mind you must have the capacity to serve the regions/counties that are checked. Adult Day Health (ADH), Alternative Living Services (ALS) and Out-of-Home Respite providers can only check the one (1) county in which the facility is located.**

*Pss and Pssx will submit the HFR D county approval letter with the NOI

☐ Statewide

1 – Northwest GA

_____Bartow
_____Catoosa
_____Chattooga
_____Dade
_____Fannin
_____Floyd
_____Gilmer
_____Gordon
_____Haralson
_____Murray
_____Paulding
_____Pickens
_____Polk
_____Walker
_____Whitfield

2 –GA Mtns/ Legacy Link

_____Banks
_____Dawson
_____Forsyth
_____Franklin
_____Habersham
_____Hall
_____Hart
_____Lumpkin
_____Rabun
_____Stephens
_____Towns
_____Union
_____White

3 – Atlanta Regional

_____Cherokee
_____Clayton
_____Cobb
_____DeKalb
_____Douglas
_____Fayette
_____Fulton
_____Gwinnett
_____Henry
_____Rockdale

4 – Three Rivers

_____ Butts
_____ Carroll
_____ Coweta
_____ Heard
_____ Lamar
_____ Meriwether
_____ Pike
_____ Spalding
_____Troup
_____Upson

5 – Northeast Georgia

_____Barrow
_____Clarke
_____Elbert
_____Greene
_____Jackson
_____Jasper
_____Madison
_____Morgan
_____Newton
_____Oconee
_____Oglethorpe
_____Walton

6 – River Valley

_____Chattahoochee
_____Clay
_____Crisp
_____Dooly
_____Harris
_____ Macon
_____ Marion
_____ Muscogee
_____Quitman
_____Randolph
_____Schley
_____Stewart
_____Sumter
_____Talbot
_____Taylor
_____Webster

7 – Middle Georgia

_____ Baldwin
_____Bibb
_____Crawford
_____Houston
_____Jones
_____Monroe
_____Peach
_____Pulaski
_____Putnam
_____Twiggs
_____Wilkinson

8 – Central Savannah River

_____Burke
_____Columbia
_____Glascock
_____Hancock
_____Jefferson
_____Jenkins
_____Lincoln
_____McDuffie
_____Richmond
_____Screven
_____Taliaferro
_____Warren
_____Washington
_____Wilkes

9 – Heart of GA/Altamaha

_____Appling
_____Bleckley
_____Candler
_____Dodge
_____Emanuel
_____Evans
_____Jeff Davis
_____Johnson
_____Laurens
_____Montgomery
_____Tattnall
_____Telfair
_____Toombs
_____Treutlen
_____Wayne
_____Wheeler
_____Wilcox

10 – Southwest Georgia

_____Baker
_____Calhoun
_____Colquitt
_____Decatur
_____Dougherty
_____Early
_____Grady
_____ Lee
_____Miller
_____Mitchell
_____Seminole
_____Terrell
_____Thomas
_____Worth

11 – Southern Georgia

_____Atkinson
_____Bacon
_____Ben Hill
_____Berrien
_____Brantley
_____Brooks
_____Charlton
_____Clinch
_____Coffee
_____Cook
_____Echols
_____Irwin
_____Lanier
_____Lowndes
_____Pierce
_____Tift
_____Turner
_____Ware

12 – Coastal

_____Bryan
_____Bulloch
_____Camden
_____Chatham
_____Effingham
_____Glynn
_____Liberty
_____Long
_____McIntosh

PART IV – CERTIFICATION

I hereby certify that my pre-qualification documents to enroll in the EDWP (CCSP/SOURCE) Services Program are complete and contain all required materials in accordance with submission requirements established by the Department of Community Health. I understand that if my pre-qualification documents are not in accordance with submission requirements detailed in the EDWP (CCSP and SOURCE) General Services Manual, my application **will not be returned** and will not be considered to continue in the established enrollment process. I understand that if my application is not considered, I will be notified via email or mail and can resubmit during any specified recruitment cycle.

_____

Signature of person legally authorized to act
for the organization or person to whom legal authority is delegated

_____

Typed name and title of above person

_____

Date

_____

Typed name and title of person completing the application