Attachment A – Authorized Provider Services

ENROLLMENT ☐ **Initial** ☐ **Change**

1915(c) HCBS WAIVER FOR MEDICALLY COMPLEX CHILDREN
(Medically Complex Children's Waiver)

Provider Name: _____

Effective Date: _____

FOR DMHF USE ONLY:

Provider #:

Category of Service: 65

PROVIDER is authorized to participate in the following waiver services (Mark all that apply):

(X)	Medically Complex Children's Waiver Services	*FOR DMHF USE ONLY* MEDICAID PROVIDER TYPE
	FINANCIAL MANAGEMENT SERVICES	
	ROUTINE RESPITE	
	SKILLED NURSING RESPITE CARE	

The undersigned Provider Representative requests enrollment as a provider of Medicaid 1915(c) Home and Community Based waiver services identified in this Attachment. The Provider acknowledges that it meets all qualifications listed in Appendix C of the Medically Complex Children's Waiver State Implementation Plan for the covered waiver services. The provider agrees to continuously meet the qualifications throughout the period of the agreement. Providers will comply with federal HCBS settings rule requirements 42 CFR § 441.301 upon enrollment and on an ongoing basis thereafter.

_____ _____

Signature of Provider Representative *Date*

The undersigned Division of Medicaid and Health Financing (DMHF) Representative, within the Bureau of Authorization and Community Based Services (BACBS), certifies that the above designated category of service and provider type is accurate.

_____ _____

Signature of Representative
DMHF, BACBS *Date*