



STATE OF TENNESSEE
DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

**TENNESSEE
DEPARTMENT OF
INTELLECTUAL AND DEVELOPMENTAL
DISABILITIES
(DIDD)**

PROVIDER APPLICATION

FOR

CLINICAL and ANCILLARY SERVICES

General Instructions Clinical

1. All questions and correspondence regarding clinical and ancillary services should be directed to:

Email: DIDDProvider.Application@tn.gov

or

Phone: (615) 532-6530

2. Individual behavior analysts and behavior specialists who want to enter into a Provider Agreement with DIDD/TennCare must first go through the credentialing process. Contact the Director of Behavioral and Psychological Services for a credentialing application:

Bruce E. Davis, Ph.D., BCBA-D
Director of Behavioral and Psychological Services
Department of Intellectual and Development Disabilities
Phone: (615) 532-6530
E-mail: bruce.davis@tn.gov

3. This application is for clinical and ancillary services including: Behavior Analyst, Behavior Specialist, Nursing, Nutrition, Occupational Therapy (OT), Orientation and Mobility (O&M), Physical Therapy (PT), Speech, Language and Hearing (SLH) which includes Speech Language Pathology and Audiology, Environmental Accessibility Modifications, Specialized Medical Equipment/Supplies and Assistive Technology, Individual Transportation (with O&M only) and Personal Emergency Response System (PERS).
4. Applications must be completed in their entirety. Incomplete applications will result in a delay in processing while the applicant is contacted for missing information and may cause the application to be rejected.
5. Applications shall be typed. Attachments should be included at the end of the application. Only one set of attachments is required.
6. Applicants may be required to provide additional information or references at the request of the DIDD.
7. Providers may be approved for all or some of the services and/or geographic areas that are proposed by the applicant.
8. All organizations approved to provide PT, OT, Speech Language Pathology, and/or Nursing must obtain a Professional Support Services license through the Department of Health (DOH) before they can fully execute the DIDD provider agreement and begin to support individuals.
9. When an existing agency is acquired, the acquiring agency must also be approved by DIDD through this application process and be licensed as appropriate.
10. If approved, the DIDD and TennCare may enter into a provider agreement with your agency to provide services. A fully executed provider agreement is required prior to providing services and seeking reimbursement.
11. Organizations must accept DIDD payment as payment in full. No other compensation or reimbursement for services rendered shall be required from people served or their families. Available Services including rates may be found on the DIDD website at www.tn.gov/didd
12. The DIDD reserves the exclusive right to accept or reject an application.
13. Individuals must be separated from employment with the State of Tennessee for at least six months before entering into a Provider Agreement to provide contract services through the Department of Intellectual and Developmental Disabilities can be initiated.

**DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
 PROVIDER APPLICATION FOR CLINICAL AND ANCILLARY SERVICES**

Please provide the following information:

 Date of Application

 Name of Organization

 Address

 City

 State

 Zip Code

 Telephone Number

 Fax Number

 Email Address

 Executive Director/Owner

 Date of Birth

 Social Security #

 List any names used in past:

Optional

Business Ownership: (Check One Only)	Ownership Ethnicity: (Check One Only)
<input type="checkbox"/> G Government Owned	<input type="checkbox"/> A Asian
<input type="checkbox"/> E Race/Ethnic	<input type="checkbox"/> B African American
<input type="checkbox"/> N Non-Minority Owned	<input type="checkbox"/> H Hispanic
<input type="checkbox"/> W Female Owned	<input type="checkbox"/> I Native American Indian
<input type="checkbox"/> P Non-Profit Background (Minority Owned)	<input type="checkbox"/> C Caucasian
	<input type="checkbox"/> O Other

1. From the following list, identify the clinical and/or ancillary services you propose to provide:

- Behavior Analyst
- Behavior Specialist
- Nursing Services
- Nutrition Services
- Occupational Therapy
- Occupational Therapy Assistive Technology*
- Orientation and Mobility
- Personal Emergency Response System
- Physical Therapy
- Physical Therapy Assistive Technology*
- Speech, Language and Hearing Services
- Speech, Language and Hearing Services Assistive Technology*
- Specialized Medical Equipment/Supplies and Assistive Technology
- Environmental Accessibility Modifications
- Individual Transportation (Only for providers of Orientation & Mobility)

** Requires special approval for individuals/agencies with advance skills/experience with assessment and intervention of Assistive Technology Devices. Please send detailed description of experience and skills with Assistive Technology.*

2. Identify the region(s) in which you propose to provide services.

East Middle West

3. List applicable state licenses or certifications, which the organization holds:

4. Are you an Employee of the State of Tennessee? Yes No

5. Have you been an employee of the State of Tennessee within the last six (6) months? Yes No

6. If yes, date of employment: _____ Date of separation _____

7. Have you been denied a license or had a license suspended or revoked in Tennessee or any other state?

No Yes

If yes, please list where and date: _____

A criminal background check will be conducted on applicants and must be conducted on all persons employed to work with persons with intellectual and developmental disabilities. This must be done through the Tennessee Bureau of Investigation or Federal Bureau of Investigation or a licensed investigation agency. The results of your criminal background check are sent directly to DIDD Central Office.

8. Has the organization and/or any of the organization's employees, agents, independent contractor and/or proposed subcontractor(s) been convicted of a crime involving injury or harm to person(s), financial or business management (e.g., assault, battery, robbery, embezzlement, fraud), or plead guilty to any contract crime involving a public contract?

No Yes

If yes, please list what charge, where convicted, and date: _____

9. Is there any pending litigation against the company that is not disclosed in the most recently audited financial statement?

No Yes

If yes, please explain giving details and providing an opinion of counsel that the pending litigation will not impair the individual/companies performance. (Attach opinion of counsel).

10. Have you ever been convicted, forfeited bond, or are you currently on probation for any felony (or any equal offense under military law)? A felony is defined as an offense punishable by imprisonment for a term of one year or greater.

No Yes

If yes, give details on a separate sheet of paper for each felony offense. Include (1) date, (2) charge, (3) place, (4) court, and (5) action taken. You must disclose any felony conviction involving a sentence or suspended sentence. You may omit: (1) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court; (2) any conviction which has been expunged under Federal or state law. A conviction will not necessarily disqualify you from the job for which you are applying. A conviction will be judged on its own merits with respect to time, circumstances, and seriousness. Application for certain positions may require additional background investigation.

Name and Title of Individual(s) preparing this Application

Checklist of items that must be attached to this application:

- _____ A comprehensive description of applicable services the organization plans to provide.
- _____ A description of any applicable experience with persons with intellectual/developmental disability.
- _____ A policy for assuring staff coverage and service schedule.
- _____ An organizational chart showing administrative structure of organization (if applicable).
- _____ Copies of relevant licenses/certifications, accreditations, or proof of professional qualifications.
- _____ Contact information for at least three (3) individuals who can provide a reference regarding your professional services and skills. Provide at least one (1) who has known the applicant for at least five (5) years.
- _____ Provide a copy of applicant's Automobile Liability Insurance (only if an Orientation and Mobility Specialist who will be transporting service recipients in a personal vehicle).

Signature Section

1. I certify that the information given in this application is correct and complete to the best of my knowledge. I am aware that should investigation show any falsification, my organization will not be considered as a potential provider of DIDD services. I hereby authorize the State of Tennessee to make all necessary investigations concerning the applicant. I further authorize and request each former employer, educational institution, or organization (including law enforcement agencies) to provide all information that may be sought in connection with this application.
2. The agency will carry adequate and appropriate general liability, professional liability, and workers compensation insurance (as applicable) for the protection of clients, staff, facilities, and the general public.

Signature: _____ Date: _____

Title: _____

Agency: _____

Please return completed application and all required attachments to:

E-mail: DIDDProvider.Application@tn.gov