## USING PSM AS AN APPLICANT TO BECOME A PROVIDER

Once accessing the PSM-portal, applicant will see the following screen



To start a new application, click on "Start a New Contract" and the following screen opens. There is also a list of all the fees. At the bottom click on 'Continue' to get to the next page.

etting Started				
Providers of services to people people accessing services thro services. An Individual or agen - A birth certificate is a rec provide an official driver: - You will need to gather a application system prom directly from the Ohio At Disabilities (DODD). The requesting your BCI, ple be used for the FBI chec - Please be aware that du days to submit all of you action will be taken. - The date that the last of will review your applicati - Following the review of y For new agency applicat - New State of Ohio suppl Administrative Knowledg	with developmental disabilitie: ugh the Ohio Department of D cy is prohibited from providing juired document and will need s' abstract from the Bureau of 1 all documents (except the BCI) pts you. Once this is complete torney General's office. BCI Ba background check process ca ase use the following code for k only). Any BCI specific quest ing the review process, you m r required documentation. Plea your application documentation ow rithin 30 days of this submi four application and document ths: Medicaid will likely require lers must first register online w	s may be self-employed individu avelopmental Disabilities (DODE any service until certification is o to be submitted as part of your i <i>lotor</i> Vehicles (BNV). prior to completing the applicatii d, you will be able to pay your fe ckground Checks must be maile in take up to 30 days, so please your reason fingerprinted: BCI ( isons you may have can be direc ay be asked to provide addition ise note that if all documentation is received (including receipt o ssion date. ation by DODD, your information and conduct a site visit of your a tith the Ohio Office of Budget an	als (independent providers) or agenc b) is important to us, DODD certifies bitained from DODD. nitial application. Independent Provic on. You must upload all of your docu e and submit your application. The E ed directly from the BCI office to the if allow enough time for the Departme Code: 5123.169. The reason code for ted to the BCI call center at 1-877-22 al documentation. If additional docum is not received within this timeline, t f the BCI), is the date that your appli- u will be submitted to Medicaid for ap agency prior to the approval of a Medi d Management (OBM) using the Sup: "Benister a New Account". Once wo	cies. Because the health and safety of both agency and independent providers of ders of transportation services must imentation (except the BCI) when the 3CII background check must be received Ohio Department of Developmental int to receive the document. When r an FBI check is: 5126.28 (this code is to 24-0043. nentation is requested, you will have 30 the application will close and no further cation will be submitted for review. DODD proval and issuing of a Medicaid number. Jicaid number.

The following appears. Choose which type of provider applying for.

				Home Provider	Dashboard LaS	alvia, Samant
Getting Started	Introduction	Intent	More Information	Summary	Summary	
10%					Name:	Samantha La
Introduction					Application Number	ROV-APP-
					Application Type:	Initial
Provider Type 😗					Status:	Draft
<ul> <li>○ Agency ♀</li> <li>○ Independent ♀</li> <li>○ Unpaid Support Broker ♀</li> </ul>					Start Date:	12/04/2017
	unicate		Save	e and Exit Save And Cor	inu	

## Once selected, demographic information appears to be filled out

A Getting Started	Introduction	II Intent	<u> </u>	More Information		Summary	×
10%						Name	Comontha LaCabria
ntroduction						Application Numb	er: PROV-APP-75015
						Application Type:	Initial
Provider Type 😯						Status:	Draft
Agency 3						Start Date:	12/04/2017
Unpaid Support Broker 🚱							
						_	
Independent Provider Demographics 📀							
Search for Existing Demograp	hic Informatio	n					
Social Security Number*		Date of Birth*		Search			
123-45-6789		03/18/1988		Search			
Eirst Name*		Middle Initial		Last Name*		_	
Samantha				LaSalvia			
0-mdat							
Female	~	03/18/1988		123-45-6789	nper		
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							1210112011
First Name*		Middle Initial		Last Name*			
Samantha				LaSalvia			
Gender*		Date of Birth*		Social Security N	lumber*		
Female	~	03/18/1988		123-45-6789			
City of Birth*		State of Birth*		Country of Birth*			
Cleveland		ОН	~	UNITED STATE	es 🗸		
Email*		Social Security Number Ef	fective Date*				
samanthalasalvia@gmail.com		03/18/1988					
Cancel Back 🖵 Communica	te			Sa	we and Exit Save And Cor	ntinue	
	_						
						A Dr.	8:48 AN

Click Next, and this screen appears.

ry Service Location 🐨				Summary
Name*	Middle Initial	Last Name*		
nantha		LaSalvia		Name: Saman
ing Name				Application Type: Initial
				Status: Draff
				Start Date: 12/04/2
ess Line 1*	Address Line 2			
1 Deepwood Blvd				
	State*	Zip*	Zip4	
ntor	он 🗸	44060		
e 1* Extn	Fax 1	Email*		
-350-5123		samanthalasalvia@gmai	l.com	
e 2 Extn	Fax 2	County*		
		LAKE	~	
the below check boxes if the corresponding a ome Office ternative Address	address is the same as the Primary Address. □Billing Address	☐Mailing Address		
Office				

Once that is complete, click 'Save and Continue'.

Applicant will choose what service group applies to them.

ntroduction	🕨 🏭 Intent	More Information	Sur 📃 Sur	nmary	Summary	
					Name:	Samantha Las
					Application Number:	PROV-APP-7
					Provider Type:	Independent
					Application Type:	Initial
					Status:	Draft
s Provider Partner 🕄					Start Date:	12/04/2017
			Save and Exit	Save And Continu		
	es Provider Partner 🕢	es Provider Partner	es Provider Partner	es Provider Partner 🕢	as Provider Partner 🕢 Save and Exit Save And Continu	as Provider Partner

Once a service group is selected, the list of all available services will appear. They are in categories.

		Name:	Samantha
Choose Service Group		Application Number:	PROV-AF
Waiver & Non-Waiver Services      Opportunities for Ohioans with Disabilities Provider Partner		Application Type:	Initial
O Non-Waiver services only 😧		Status:	Draft
		Start Date:	12/04/201
Expand All			
+ Employment Services	+ Adaptive Technology and Environmental Modifications		
+ Transportation Services	+ Homemaker and Personal Care Services		
+ Professional Services	+ Nutrition and Meal Services		
+ Respite or Long Term Care Services	+ Adult Day Services		
+ Support Brokerage	+ County Board Services		

The applicant will go through and select each service they want to provide. When clicking on a service, a box will pop up describing the service. The applicant must hit proceed to add it.

whole hour hour hour hour hour		C S Home Page	S Provider Certification wizard	C Ivew Provider Application A		
Favorites Tools He	elp					
ty Board of DD 🧲	Google 🥘 Home DODD 💣 Home Page	fn DODD MyLearning				
					-	i i i i i i i i i i i i i i i i i i i
					hboard LaS	
	30%	Shared Living	×			
S	Services	'Shared living' means personal care and s	upport services provided to an adult by a			
		caregiver who lives with the individual rece	eiving the services. Shared living is provided in		Name:	Samantha LaSalvia
	Choose Service Group	conjunction with residing in the home and when people live together in the same hor	is part of the rhythm of life that naturally occurs		Application Number	PROV-APP-75015
	Waiver & Non-Waiver Services	together in the same home, segregating th	nese activities into discrete services is impractical.		Provider Type:	Independent
	Opportunities for Ohioans with Disab	The DODD Provider Certification Application	on Fee is applicable for this service.		Application Type:	Initial
	○ Non-Waiver services only ⑧				Status:	Draft
		Dismiss	Proceed		Start Date:	12/04/2017
	Choose Service Category				Start Date.	12/04/2017
	Expand All					
	+ Employment Services		+ Adaptive Technology and Environmental	Modifications		
	+ Transportation Services		- Homemaker and Personal Care Services			
			Community InclusionPersonal Assistance (SE	ELF Service) 😧		
			Homemaker Personal Care			
			Cherrod Living			
			El Shared Living 🐨			
	+ Professional Services		+ Nutrition and Meal Services			i i i i i i i i i i i i i i i i i i i
	+ Respite or Long Term Care Serv	rices	+ Adult Day Services			i i i i i i i i i i i i i i i i i i i
	+ Support Brokerage		+ County Board Services			

The selected services will be listed below. Once it is complete, hit 'Save and Continue'.

+	Respite or Long Te	rm Care Services		+ Adult Day Services		1
+	Support Brokerage			+ County Board Services		
	nice Counties					
Selec	ted Service County (E	By default, all services are certified for the county of your	prima	ry address.)		
	Certified Service	My business operates in the following counties	My	Business is currently accepting new Individuals in the following counties		
Edit	Shared Living	LAKE	LA	KE		
Car	ncel Back 📮	Communicate		Save and Exit Save And Continue		
						~
w	1 😑 🚺				▲ ▶ 117 at ♦ 8:53 A 12/4/20	M 017

The disclosures appear for the applicant to fill out, as well as the area to upload the documents to and the nondisclosure agreement.

NOTE: Applicants are now required to get their Ohio Supplier ID number BEFORE submitting the application, it is part of the required documentation. See instructions within the application below.

				Home Pro	wider Dashboard	.aSalvia, Samantha
f Getting Started	L Introduction	Intent	C More Information	Summary	Summary	
	50%				Name:	Samantha LaSa
Nore Information					Application Num	ber: PROV-APP-750
					Provider Type:	Independent
Disclosures					Application Type	: Initial
Are you a MBE (Minority Busi	iness Enterprise) Business?				Status:	Draft
○ Yes ○No					Start Date:	12/04/2017
Are you an EDGE (Encouragi	ing Diversity, Growth, and Equity	) business?			Fee Due :	\$125.00
○ Yes ○No					ODM Fee Due :	\$0.00
Are you currently or have you	ever been an employer or emplo t history at another DODD certifie	byee at an agency serving individ	uals with developmental disabilities?	ied agency	Services <ul> <li>Shared L</li> </ul>	iving
Do you have a family membe	r who provides or has provided se	ervices for DODD to a development	entally disabled person? "Relative" applies	s to your current or forme	r spouse.	
○ Yes, I do have a relative w	ho is/was certified. ONo, I do not	have a relative who is/was certif	ied			
Do you have a business asso	ciate(s), who are or were certified	d to provide services through the	Ohio Department of Developmental Disab	pilities (DODD)?		
$\bigcirc$ Yes, I do have a business	associate who is/was certified $\bigcirc$ I	No, I do not have a business ass	ociate who is/was certified			
If you have received your Nat	ional Provider Identifier (NPI) nur	mber, please report it here.				
NPI Number						
Save						
If you had a previous Nationa	l Provider Identifier (NPI) number	r please report it here				
NPI Number		, please report it here.				
ovider/Application/Index/4e811865-	<del>-f9d8-e711-80d6-005</del> 056b52d1d					
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Sous					s	ummary	
Save					Nan	ne:	Samantha
Are you currently certified throu	ugh the Ohio Department	of Aging and/or the Ohio Departr	ment of Job and Family Service	es?	Ann	lication Number	
⊖ Yes ⊖No					Bro	vider Tupe:	Independent
Enter all the languages you spe	eak/write				Apr	vider type.	Independent
Language			Start Date		App	nication type.	Initiai
Select	~		12/4/2017		Star	us:	Draft
End Date					sta	rt Date:	12/04/2017
12/4/2017					Fee	Due :	\$125.00
					ODI	M Fee Due :	\$0.00
Add					Ser	<ul> <li>Shared Livin</li> </ul>	a
Language		Start Date		End Date			'a
ENGLISH		03/18/1988		12/31/2999			
○ Yes ONo Please provide the Supplier ID digit number, including any leas online with the Ohio Office of B www.supplier.obm.ohio.gov an	assigned to you and your ding 0's.) If you already hi Budget and Management ( id click 'Register a New Ai	r TIN (agency) or SSN (independ ave a State of Ohio supplier num (OBM) using the Supplier Self-Re ccount'. Once you are assigned a	ent provider) by Ohio Shared 3 ber, please enter it here. Othe gistration module of the Ohio . a Supplier Number, you will ne	Services Office of Budget and Managemen wise, new State of Ohio suppliers must fil Administrative Knowledge System (OAKS ed to upload a copy of an email or screen:	nt. (This is a 10 rst register ). Go to shot of your		
account showing your name an	nd assigned Supplier Num	ber in the document upload belo	w.				
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Please provide the Supplier ID a digit number, including any leadi online with the Ohio Office of Bu www.supplier.obm.ohio gov and account showing your name and Supplier ID * * required Save Secondary Contacts First Name * Add SecondaryContact RAPBACK Pursuant to Administrative Code Rapback is a criminal backgroun xrocessing. consent to enrollment by the Oh	issigned to you and your 1 ng 0's.) If you already hav dget and Management (C click :Register a New Acc I assigned Supplier Numb 5123:2-2-01, Providers n d check system. By initial hio Department of Develo Independen Initials*	TIN (agency) or SSN (independe e a State of Ohio supplier numb IBM) using the Supplier Self-Reg count: Once you are assigned a i er in the document upload below Last Name nust "consent to be enrolled in th ling this consent and submitting y pmental Disabilities in the Ohio a t Provider	nt provider) by Ohio Shared S er, please enter it here. Other istration module of the Ohio A Supplier Number, you will nee Email e Ohio attorney general's reta your application, you are conse ittorney general's retained app	ervices Office of Budget and Managemeni vise, new State of Ohio suppliers must firs dministrative Knowledge System (OAKS) d to upload a copy of an email or screensi to upload a copy of an email or screensi Phone Phone ned applicant fingerprint database (Rapb unting to Rapback enrollment as part of you licant fingerprint database (Rapback).	L (This is a Su of register Go to hot of your Appi Statu Statu Servi	immary e: lication Number: lider Type: lis: Date: Date: Date: lices • Shared Living	Samantha Li PROV-APP- Independent Initial Draft 12/04/2017 \$125.00 \$0.00

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Documents		Name:	Samantha LaSalvia
These documents are required in order to be an Obio Medicaid E	provider, and you cannot become certified until you have submitted these documents to the denartment. Yo	Application Number	PROV-APP-75015
must scan and upload the documents here to proceed with subm	itting your application.	Provider Type:	Independent
		Application Type:	Initial
BCII Background Checks cannot be uploaded to the Department This process can take up to 30 days, so please allow enough tim	They must be mailed directly from the BCII office to the Ohio Department of Developmental Disabilities. e for the Department to receive the document. When requesting your BCII, please use the following code	Status:	Draft
for your reason fingerprinted:		Start Date:	12/04/2017
BCII Code: 5123.169		Fee Due :	\$125.00
Please have your BCII sent to the following address (only BCIIs)	will be accented through the mail):		\$125.00
Please have your bon sent to the following address (only bons i	ni be accepted through the mail).	ODM Fee Due .	\$0.00
The Ohio Department of Developmental Disabilities		Shared Livir	a
Attention Provider Certification		onaroa Erri	9
30 E. Broad Street	l		
13th Floor			
Columbus, Ohio 43215			
Max file size limit for upload is 75 MB and allowable file type	s are .doc, .docx, .pdf, .jpeg, .jpg,.tig, .png, .txt .tif, .tiff, .gif.		
		-	
Please, ensure that all Required Documents have a corresponding	ng Document Upload except the BCII and FBI, as listed		
8 hour Initial Certification Training	BCI Background Check 📀		
Birth Certificate			
First Aid	High School Diploma/GED 3		
Initial Overview 📀	OSS Verification of Supplier Number 📀		
🗌 Social Security Number 😯	State of Ohio Identification 😧		
W-9 O Download W9			

	Name:	Samantha LaSalvia
Attestations	Application Number:	PROV-APP-75015
Each independent provider; each CEO of an agency provider; and each employee, contractor, and employee of a contractor of an agency provider who is engaged in a dire services position must meet the following requirements. Furthermore, by initialing this page, you indicate your understanding and assurance to comply with the following	Provider Type:	Independent
requirements.	Application Type:	Initial
<ul> <li>Applicant has read and understands the requirements of only Auministrative Gode Chapter 3123.2. These rules can be round at. http://dodd.ohio.gov/RulesLaws/Pages/RulesInEffect.aspx</li> </ul>	Status:	Draft
<ul> <li>Applicant will comply with the requirements of Ohio Administrative Code Chapter 5123:2.</li> </ul>	Start Date:	12/04/2017
<ul> <li>Applicant will comply with the requirements of all relevant state and federal statutes and state and federal rules.</li> <li>Applicant confirms that the information provided in this application is complete and accurate. Misrepresentations, false statements, inaccurate statements, or</li> </ul>	Fee Due :	\$125.00
incomplete statements may result in a denial of the application or in the suspension or revocation of a provider's certification.	ODM Fee Due :	\$0.00
• In accordance with Executive Order 2011-03K, Applicant confirms: (1) it has reviewed and understands Executive Order 2011-03K, (2) it has reviewed and	Services	
understands the Ohio ethics and conflict of interest laws, and (3) it will take no action inconsistent with those laws and the Order. Applicant understands that failure to comply with Executive Order 2011-03K is grounds for denial of the application or suspension or revocation of a provider's certification and may result in the loss of other contracts or grants with the State of Ohio.	Shared Living	g
☑ I accept the terms and conditions mentioned above.*		
Applicant Initials* SL		
Agree		
Non Disclosure Agreement		
I acknowledge that I will be provided access to information, systems, operations, or procedures that are security sensitive or have been identified as confidential by the Ohio Department of Developmental Disabilities (DODD), the State of Ohio, or the United States of America. Each person authorized to access DODD systems holds a position of trust relative to this information and must recognize the necessity to keep this information confidential and secure. As such, I agree to the following:	^	

<form></form>		Agree	Name:	Samantha LaSal
<form><ul> <li>Note that is a state of the second of the second</li></ul></form>			Application Number:	PROV-APP-7501
<form></form>	Non Disclosure Agreement		Provider Type:	Independent
<form></form>	ieuerariaw,		Application Type:	Initial
<form></form>	<ul> <li>I hat the information may repribe restricted or prohibited by state</li> </ul>	esent conindential personal information, protected nealth information, or prophetary information, the release or disclosure of which may state and federal law;	Status:	Draft
<form></form>	That I shall regard all such infe	ormation as confidential and that I shall not disclose, reveal, communicate, impart, or divulge the information or any summary or	Start Date:	12/04/2017
<form></form>	<ul> <li>synopsis of the information in</li> <li>That DODD has instituted sec</li> </ul>	any manner or any form whatsoever; curity measures designed to identify attempts to tamper with the websites, systems, operations, or procedures and that information	Fee Due :	\$125.00
<ul> <li>a. banck under standing security measures designed to monitor and detect the insultinonization costs on taken in the designed cost on the standing on the designed cost on the standing on</li></ul>	collected through theses secu	rity measures may be used in connection with a criminal prosecution or other legal proceedings;	ODM Fee Due :	\$0.00
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<form>Applicant initial</form>	By signing this statement, I acknow	vledge that I understand and agree to adhere to the limitations on access and disclosure described above.	·	
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Advance of the second s		Agree		
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a description of false claims laws, whistleblower protections and detailed provisions for detecting and preventing fraud, waste and abuse.  14. ciuly cooperate with the Department, its agents, and other state or faderal agencies engaged in ensuring the integrity of the Ohio Medicaid program. Full cooperation includes, but is not limited to, making yourself and your records available upon request.  15. This provider agreement may be canceled by either party upon 30 days written notice prior to termination date.  16. Hurther certify that I am the individual practitioner who is applying for the provider number. If urther agree to be bound by this agreement, and certify that I have given on this application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, in the disclosed my name, social security number and date of birth on the application for enrollment, includes, and as specified in rule 5160-1-17.3 of the Administrative Code.  15. The Medicaid Agreement has changed since it was last agreed by you. Please read the Agreement text and confirm your acceptance.  16. I accept the terms and conditions mentioned above.*  17. Type your full name as your Electronic Signature.  16. Agree  17. Cancel  16. Back  17. Communicate  17. Genet  17. Save and Exit  18. Save And Continue  18. Save and Exit	This provider agreement is a contra Provider agrees to comply with the	act between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies me Demics resourcement. The treatment accounts on the annu care enumers who receive medicate termoursements or so oucourd per vers	Name: Application Number: Provider Type:	Samantha LaS PROV-APP-75 Independent
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<ul> <li>15. This provider agreement may be canceled by either party upon 30 days written notice prior to termination date.</li> <li>16. Intrare certify that I am the individual practitioner who is applying for the provider number. I further agree to be bound by this agreement, and certify that the thin information I have given on this application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrolment, information I have given on this application. I save given on this application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrolment, information I have given on this application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrolment, information I have given on this application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrolment, information I have given on this application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrolment, information I have given on this application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrolment, information accordance with 42 CFR, Part 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5160-1-17.3 of the Administrative Code.</li> <li>The Medicaid Agreement has changed since it was last agreed by you. Please read the Agreement text and confirm your acceptance.</li> <li>I accept the terms and conditions mentioned above.*</li> <li>Type your full name as your Electronic Signature.</li> <li>I accept the terms and conditions</li> <li>Gametia LaSalvia</li> <li>Gametia</li> <li>Gametia</li> <li>Cancel</li> <li>Back</li> <li>Communicate</li> </ul>	Medicald Provider Agreement This provider agreement is a contra Provider agrees to comply with the Ts. Comply with security with security or more, to establish written p a description of false claims is 4. Sult assessment with the Dense	Act between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies une Dencit Reduction ACC. This requirement applies to meanic care enumes who receive medicato removements or so, our, our per year solicies for all their own employees and contractors to provide information about the False Claims Act, provide remedies for false claims, aws, whistleblower protections and detailed provisions for detecting and preventing fraud, waste and abuse.	Name: Application Number: Provider Type: Application Type: Status:	Samantha LaS PROV-APP-75 Independent Initial Draft
16. Infurther certify that I am the individual practitioner who is applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, information I have given on this application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, information I have given on this application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, information I have given on this application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, information I have given on this application sing that a greed by you. Please read the Agreement text and confirm your acceptance. <ul> <li>I accept the terms and conditions mentioned above.*</li> <li>Type your full name as your Electronic Signature.</li> <li>I accept the terms and conditions</li> <li>Gamantha LaSalvia</li> <li>Samantha LaSalvia</li> <li>Gament</li> </ul> Cancel  Back  Communicate  Define the formation of the security and the application of continue  Save and Exit  Save and Exit  Save and Exit  Save and Exit Save And Continue  Save and Exit  Save and Exit	This provider agreement is a contra Provider agrees to comply with the 1.5. Comply with section tods of or more, to establish written p a description of failse claims I 14. Fully cooperate with the Depa includes, but is not limited to,	act between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies the Dencit Reduction ACL. This requirement applies to hearin care ensures who receive medicato termoursements or so, uou oper year solicies for all their own employees and contractors to provide information about the False Claims Act, provide remedies for false claims, aws, whistleblower protections and detailed provisions for detecting and preventing fraud, waste and abuse. artment, its agents, and other state or federal agencies engaged in ensuring the integrity of the Ohio Medicaid program. Full cooperation making yourself and your records available upon request.	Name: Application Number: Provider Type: Application Type: Status: Start Date:	Samantha LaS PROV-APP-75 Independent Initial Draft 12/04/2017
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accordance with 42 CFR, Part 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5160-1-17.3 of the Administrative Code.   The Medicaid Agreement has changed since it was last agreed by you. Please read the Agreement text and confirm your acceptance.   I accept the terms and conditions mentioned above.*   Type your full name as your Electronic Signature.   I accept the terms and conditions   Samantha LaSalvia   Concel   Back   Communicate   Save and Extl Save And Continue Save and Extl Save And Continue Save and Extl	This provider agreement is a contra- Provider agrees to comply with the This provider agrees to comply with the The comply with section eosy of or more, to establish written price a description of false claims is 14. Fully cooperate with the Depa- includes, but is not limited to, 15. This provider agreement may 16. I further certify that I am the in officer or ensered nether of f	act between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies inter Denick reduction Act. This requirement applies to mean care enuises wind receive medicator terminous entents or 30,000,000 per year solicles for all their own employees and contractors to provide information about the False Claims Act, provider emedies for false claims, aws, whistleblower protections and detailed provisions for detecting and preventing fraud, waste and abuse. artiment, its agents, and other state or federal agencies engaged in ensuring the integrity of the Ohio Medicaid program. Full cooperation making yourself and your records available upon request.	Name: Application Number: Provider Type: Application Type: Status: Start Date: Fee Due : ODM Fee Due :	Samantha LaS PROV-APP-75 Independent Initial Draft 12/04/2017 \$125.00 \$0.00
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I accept the terms and conditions mentioned above.* Type your full name as your Electronic Signature. I accept the terms and conditions Samantha LaSalvia Samantha LaSalvia Agree Cancel Back Communicate Save and Exit Save And Continue	<ul> <li>Medicard Provider Agreement</li> <li>This provider agreement is a contre Provider agrees to comply with the 13. Comply with section ous2 or or more, to establish written p a description of false claims is 14. Fully cooperate with the Depenicitudes, but is not limited to.</li>         15. This provider agreement may 16. I further certify that I am the in officer, or general partner of ti information I have given on th accordance with 42 CFR, Par </ul>	act between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifie: the Denick reduction Act. This requirement applies to meanic care enumes who receive medicator terminousements or 30,000,000 per year solicies for all their own employees and contractors to provide information about the False Claims Act. provide remedies for false claims, aws, whistleblower protections and detailed provisions for detecting and preventing fraud, waste and abuse. aritment, its agents, and other state or federal agencies engaged in ensuring the integrity of the Ohio Medicaid program. Full cooperation making yourself and your records available upon request. to be canceled by either party upon 30 days written notice prior to termination date. ndividual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive he business organization that is applying for the provider number, or in the torse to be bound by this agreement, and certify that the is application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, in t 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5160-1-17.3 of the Administrative Code.	Name: Application Number: Provider Type: Application Type: Status: Start Date: Fee Due : ODM Fee Due : Services • Shared Living	Samantha LaS PROV-APP-75 Independent Initial Draft 12/04/2017 \$125.00 \$0.00
Type your full name as your Electronic Signature.  I accept the terms and conditions Samantha LaSalvia Agree Cancel Back Communicate Save and Exit Save And Continue	<ul> <li>Medicaid Provider Agreement</li> <li>This provider agreement is a contre Provider agrees to comply with the To: Comply with section ouss or or more, to establish written p a description of false claims is fully cooperate with the Depenincludes, but is not limited to. This provider agreement may 16. I further certify that I am the in officer, or general partner of t information I have given on th accordance with 42 CFR, Par The Medicaid Agreement has char</li> </ul>	act between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifie: Inter Denick reduction Act. This requirement applies to meanic care enuates who receive medicator terminousements or 30,000,000 per year Solicles for all their own employees and contractors to provide information about the Flates Claims Act, provide remedies for false claims, aws, whistleblower protections and detailed provisions for detecting and preventing fraud, waste and abuse. aritment, its agents, and other state or federal agencies engaged in ensuring the integrity of the Ohio Medicaid program. Full cooperation making yourself and your records available upon request. the canceled by either party upon 30 days written notice prior to termination date. Individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive he business organization that is applying for the provider number, or in the case of a business organization, I am the officer, chief executive he business organization that is applying for the provider number, or in the case of a business organization, I am the officer, chief executive he business organization that is applying for the provider number, or in the case of a business organization, I am the officer, chief executive he sapplication is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, in t 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5160-1-17.3 of the Administrative Code.	Name: Application Number: Provider Type: Application Type: Status: Stat Date: Fee Due : ODM Fee Due : Services • Shared Living	Samantha LaSi PROV-APP-750 Independent Initial Draft 12/04/2017 \$125.00 \$0.00
Laccept the terms and Samantha LaSalvia Samantha LaSalvia Agree	<ul> <li>Medicaid Provider Agreement</li> <li>This provider agreement is a contrative provider agreement is a contrative provider agrees to comply with section of section of section of a description of false claims is a description of false claims is a description of false claims is not limited to.</li> <li>This provider agreement may 16. I further certify that I am the in officer, or general partner of the information I have given on the accordance with 42 CFR, Par</li> <li>The Medicaid Agreement has chart is a conditive to the terms and condition to the terms and condition to the terms and conditional terms and t</li></ul>	act between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifie: Inter Denick reduction Act. This requirement applies to meanic care enuites wino receive medicator terminousements or 30,000,000 per year Solicles for all their own employees and contractors to provide information about the Flates Claims Act. provide remedies for false claims, aws, whistleblower protections and detailed provisions for detecting and preventing fraud, waste and abuse. aritment, its agents, and other state or federal agencies engaged in ensuring the integrity of the Ohio Medicaid program. Full cooperation making yourself and your records available upon request. to be canceled by either party upon 30 days written notice prior to termination date. Individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive he business organization that is applying for the provider number, or in the case of a business organization. I am the officer, chief executive he business organization is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, in t 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5160-1-17.3 of the Administrative Code. toged since it was last agreed by you. Please read the Agreement text and confirm your acceptance. and since it was last agreed by you. Please read the Agreement text and confirm your acceptance.	Name: Application Number: Provider Type: Application Type: Start Date: Fee Due : ODM Fee Due : Services • Shared Living	Samantha LaSi PROV-APP-750 Independent Initial Draft 12/04/2017 \$125.00 \$0.00
Conditions Samantha LaSalvia  Agree  Cancel Back Communicate  Save and Exit Save And Continue  Wa Save and Exit Save And Continue	<ul> <li>Medicaid Provider Agreement</li> <li>This provider agreement is a contre Provider agrees to comply with the 13. Comply with section 1002 of or more, to establish written p a description of false claims is 14. Fully cooperate with the Depa includes, but is not limited to.</li> <li>15. This provider agreement may 16. I further certify that I am the in officer, or general partner of t information I have given on th accordance with 42 CFR, Par</li> <li>The Medicaid Agreement has char Ø I accept the terms and conditi Type your full name as your Elec</li> </ul>	act between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifier une Denick reduction Act. This requirement applies to mean care enuates who receive medicain terminousements or 30,000,000 per year oblices for all their own employees and contractors to provide information about the Flates Claims Act. provide remedies for false claims, aws, whistleblower protections and detailed provisions for detecting and preventing fraud, waste and abuse. aritment, its agents, and other state or federal agencies engaged in ensuring the integrity of the Ohio Medicaid program. Full cooperation making yourself and your records available upon request. 'be canceled by either party upon 30 days written notice prior to termination date. Individual practitioner who is applying for the provider number, or in the case of a business organization. I am the officer, chief executive he business organization that is applying for the provider number, or in the case of a business organization. I am the officer, chief executive he business organization is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, in t 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5160-1-17.3 of the Administrative Code. Used since it was last agreed by you. Please read the Agreement text and confirm your acceptance.	Name: Application Number: Provider Type: Application Type: StartDate: Fee Due : ODM Fee Due : Services • Shared Living	Samantha LaSi PROV-APP-75( Independent Initial Draft 12/04/2017 \$125.00 \$0.00
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	<ul> <li>Medicald Provider Agreement</li> <li>This provider agreement is a contreprovider agreement is a contreprovider agrees to comply with the Toronder agrees to comply with section of also claims i</li> <li>full, Fully cooperate with the Deparincludes, but is not limited to, 15. This provider agreement may 16. I further certify that I am the ir officer, or general partner of the information I have given on the accordance with 42 CFR, Par</li> <li>The Medicald Agreement has char</li> <li>I accept the terms and conditi</li> <li>Type your full name as your Elect I accept the terms and conditions</li> </ul>	act between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the terms of this provider agreement, state statules, Ohio Administrative Code rules, and Federal statules and rules, and agrees and certifier into ucencin reduction ACL: This requirement applies to meanin care emines wino receive meancain reminosments or so,ouo,ooo per year oblicles for all their own employees and contractors to provide information about the False Claims Act, provide remedies for false claims, aws, whistleblower protections and detailed provisions for detecting and preventing fraud, waste and abuse. aritment, its agents, and other state or federal agencies engaged in ensuring the integrity of the Ohio Medicaid program. Full cooperation making yourself and your records available upon request. the canceled by either party upon 30 days written notice prior to termination date. Individual practitioner who is applying for the provider number, or in the case of a business organization. I am the officer, chief executive he business organization that is applying for the provider number. I further agree to be bound by this agreement, and certify that the is application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, in t 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5160-1-17.3 of the Administrative Code. Inged since it was last agreed by you. Please read the Agreement text and confirm your acceptance. The first Print Signature. Samantha LaSalvia	Name: Application Number: Provider Type: Status: Start Date: Fee Due : ODM Fee Due : Services • Shared Living	Samantha LASi PROV-APP-75i Independent Initial 12/04/2017 \$125.00 \$0.00
	<ul> <li>Medicaid Provider Agreement</li> <li>This provider agreement is a contreprovider agreement is a contreprovider agrees to comply with the Tore or more, to establish written p a description of false claims i</li> <li>Fully cooperate with the Deprincludes, but is not limited to, 15. This provider agreement may 16. I further certify that I am the ir officer, or general partner of t information I have given on the accordance with 42 CFR, Par</li> <li>The Medicaid Agreement has char</li> <li>I accept the terms and conditi</li> <li>Type your full name as your Elect I accept the terms and conditions</li> </ul>	act between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the terms of this provider agreement, state statules, Ohio Administrative Code rules, and Federal statules and rules, and agrees and certifier the Denci Reduction ACT. This requirement applies to meanin care emines who receive medicato remotes for false claims, aws, whistleblower protections and detailed provisions for detecting and preventing fraud, waste and abuse. artment, its agents, and other state or federal agencies engaged in ensuring the integrity of the Ohio Medicaid program. Full cooperation making yourself and your records available upon request. <i>t</i> be canceled by either party upon 30 days written notice prior to termination date. ndividual practitioner who is applying for the provider number. I further agree to be bound by this agreement, and certify that the is application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, in t 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5160-1-17.3 of the Administrative Code. Insembinoed above,* tronic Signature. Samantha LaSalvia Samantha LaSalvia Samantha LaSalvia Samantha LaSalvia Save and Exit Save And Continuent Save And Continuent S	Name: Application Number: Provider Type: Status: Start Date: Fee Due : ODM Fee Due : Services • Shared Living	Samantha LaS PROV-APP-75 Independent Initial 12/04/2017 \$125.00 \$0.00
	Medical Provider Agreement       This provider agreement is a contre       Provider agrees to comply with the       13. Contripy with section couse of       or more, to establish written p       a description of false claims i       14. Fully cooperate with the Deprincludes, but is not limited to,       15. This provider agreement may       16. I further certify that I am the ir       officer, or general partner of triinformation I have given on the       17. De Medicaid Agreement has charr       I accept the terms and conditi       Type your full name as your Elect       I accept the terms and conditions	act between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the terms of this provider agreement, state statules, Ohio Administrative Code rules, and Federal statules and rules, and agrees and certifier the Dencit Reduction ACC. This requirement appress to readin care ennues who receive medicain ennousements or so,oou, oop er year oblices for all their own employees and contractors to provide information about the False Claims Act, provide remedies for false claims, aws, whistleblower protections and detailed provisions for detecting and preventing fraud, waste and abuse. aritment, its agents, and other state or federal agencies engaged in ensuring the integrity of the Ohio Medicaid program. Full cooperation making yourself and your records available upon request. / be canceled by either party upon 30 days written notice prior to termination date. ndividual practitioner who is applying for the provider number, or in the case of a business organization. I am the officer, chief executive he business organization that is applying for the provider number. I writher agree to be bound by this agreement, and certify that the tis application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, in t 455. Subpart B and 1002, Subpart A, as amended, and as specified in rule 5160-1-17.3 of the Administrative Code. nged since it was last agreed by you. Please read the Agreement text and confirm your acceptance. Samantha LaSalvia Agree Agree Market Save and Exit Save And Continue Save	Name: Application Number: Provider Type: Status: Start Date: Fee Due : ODM Fee Due : Services • Shared Living	Samantha LaS PROV-APP-75 Independent Initial Draft 12/04/2017 \$125.00 \$0.00

Once complete, select 'Save and Continue'

## If information is missing (as is with this application) this screen appears describing what is missing.

				Home Pro	ovider Dashboard	👤 LaSalvia, Samantha 👻
Getting Started	L Introduction	Intent	More Information	Summary	Summary	×
	50%				Name:	Samantha LaSalvia
More Information					Application N	lumber: PROV-APP-75015
Required disclosure	text starting with "Please provide the s	Supplier ID assigned to you and	your TIN (agency) or SSN (independent pro	vider) b "	Provider Type	e: Independent
Please attest Rapba	ick for Independent Provider				Application T	ype: Initial
8 hour Initial Certific     Bith Contificate does	ation Training document is required				Status:	Draft
CPR document is re	quired				Start Date:	12/04/2017
First Aid document is	s required				Fee Due :	\$125.00
Initial Overview docu	a/GED document is required				ODM Fee Due	e: \$0.00
OSS Verification of 3     Social Security Num     State of Ohio Identifi     W-9 document is rec	Supplier Number document is required iber document is required ication document is required quired				• Share	ed Living
Disclosures						
Are you a MBE (Minority	Business Enterprise) Business?					
⊖ Yes						
Are you an EDGE (Enco	uraging Diversity, Growth, and Equity)	business?				
O Yes ●No						
Are you currently or have	e you ever been an employer or employ	yee at an agency serving indivi	duals with developmental disabilities?	d		
Yes, I do nave employ	ment history at another DODD certifie	d agency. Ono, i do not nave e	employment history at another DODD certifie	a agency.		
O Yes I do have a relativ	who is/was certified @No. I do not	have a relative who is/was cert	ified	o your current or forme	a spouse.	
Do you have a business	associate(s) who are or were certified	to provide services through the	Ohio Department of Developmental Disabili			
) 🚺 🛜 🚺	02				- 1	9:00 AM 12/4/2017