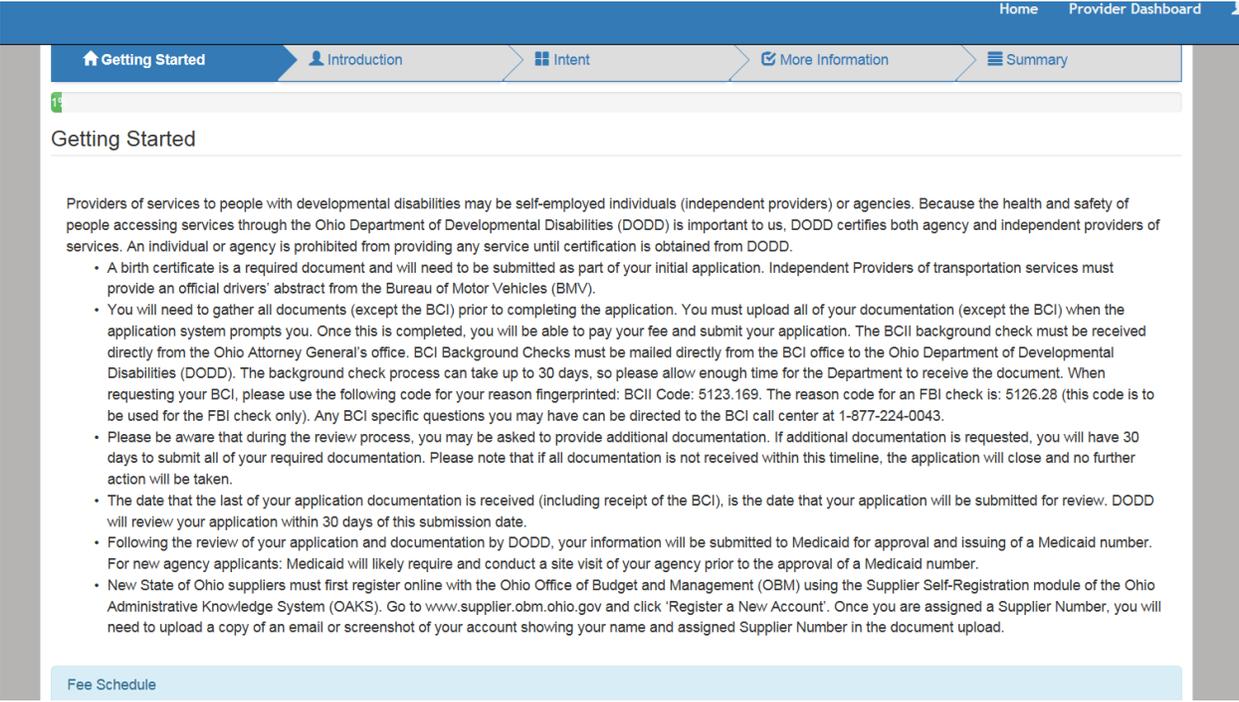


USING PSM AS AN APPLICANT TO BECOME A PROVIDER

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.



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

Getting Started Introduction Intent More Information Summary

10%

Introduction

Provider Type

Agency

Independent

Unpaid Support Broker

Cancel Back Communicate Save and Exit Save And Continue

Summary

Name: Samantha LaSalvia

Application Number: PROV-APP-75015

Application Type: Initial

Status: Draft

Start Date: 12/04/2017

Once selected, demographic information appears to be filled out

Getting Started Introduction Intent More Information Summary

10%

Introduction

Provider Type

Agency

Independent

Unpaid Support Broker

Independent Provider Demographics

Search for Existing Demographic Information

Social Security Number* Date of Birth*

123-45-6789 03/18/1988 Search

First Name* Middle Initial Last Name*

Samantha [] LaSalvia

Gender* Date of Birth* Social Security Number*

Female 03/18/1988 123-45-6789

W Spotify X O 8:48 AM 12/4/2017

First Name* Middle Initial Last Name*

Samantha [] LaSalvia

Gender* Date of Birth* Social Security Number*

Female 03/18/1988 123-45-6789

City of Birth* State of Birth* Country of Birth*

Cleveland OH UNITED STATES

Email* Social Security Number Effective Date*

samanthalasalvia@gmail.com 03/18/1988

Next

Cancel Back Communicate Save and Exit Save And Continue

W Spotify X O 8:48 AM 12/4/2017

Click Next, and this screen appears.

The screenshot shows a web application interface for a 'Primary Service Location' form. The form is titled 'Primary Service Location' and includes several input fields and checkboxes. The fields are organized into columns and rows. The 'Summary' panel on the right displays the following information: Name: Samantha LaSalvia, Application Number: PROV-APP-75015, Application Type: Initial, Status: Draft, and Start Date: 12/04/2017. The form fields are as follows:

Field	Value
First Name*	Samantha
Middle Initial	
Last Name*	LaSalvia
Building Name	
Address Line 1*	8121 Deepwood Blvd
Address Line 2	
City*	Mentor
State*	OH
Zip*	44060
Zip4	
Phone 1*	440-350-5123
Extn	
Fax 1	
Email*	samanthalasalvia@gmail.com
Phone 2	
Extn	
Fax 2	
County*	LAKE

Check the below check boxes if the corresponding address is the same as the Primary Address.

Check Box	Label
<input checked="" type="checkbox"/>	Home Office
<input type="checkbox"/>	Alternative Address
<input type="checkbox"/>	Billing Address
<input type="checkbox"/>	Mailing Address

Home Office

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

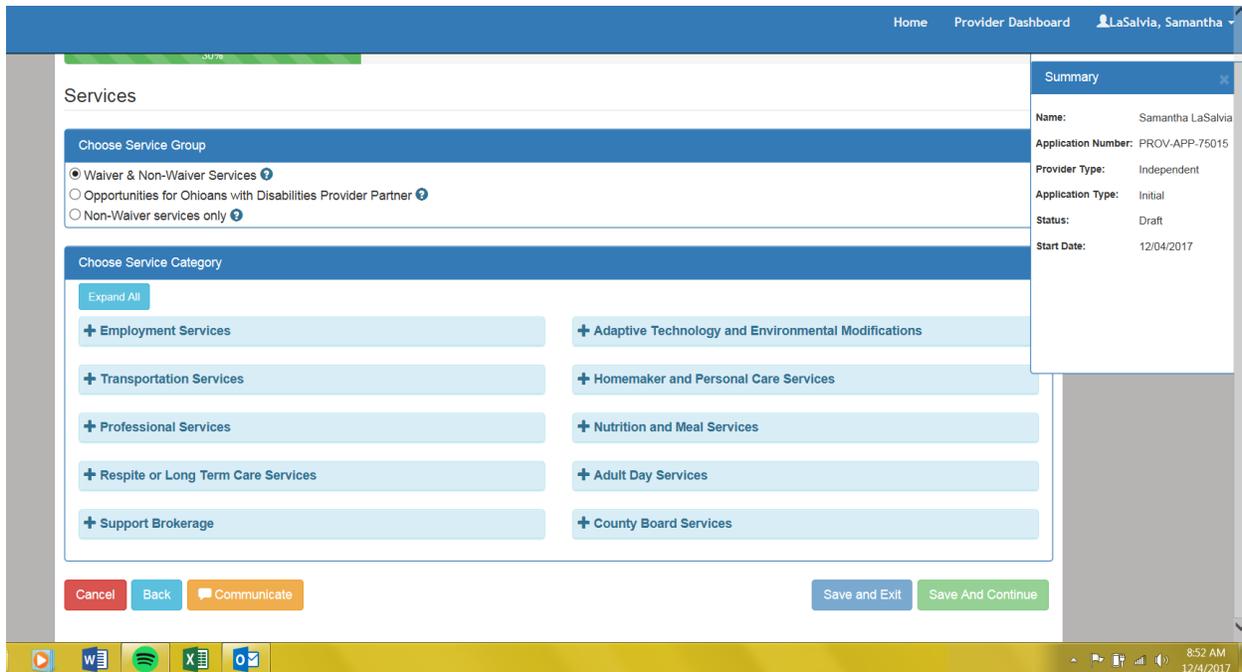
Applicant will choose what service group applies to them.

The screenshot shows a web application interface for the 'Services' selection screen. The form is titled 'Services' and includes a progress bar showing 30% completion. The 'Summary' panel on the right displays the following information: Name: Samantha LaSalvia, Application Number: PROV-APP-75015, Provider Type: Independent, Application Type: Initial, Status: Draft, and Start Date: 12/04/2017. The form fields are as follows:

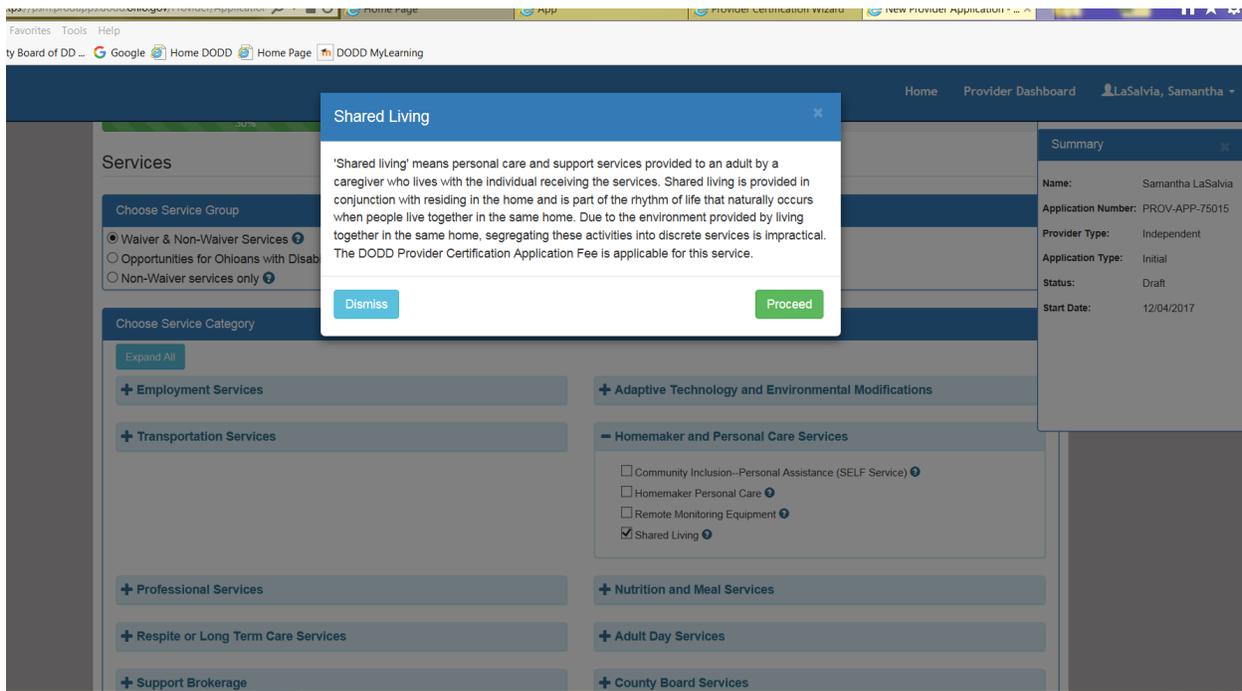
Field	Value
Choose Service Group	<input type="radio"/> Waiver & Non-Waiver Services <input type="radio"/> Opportunities for Ohioans with Disabilities Provider Partner <input type="radio"/> Non-Waiver services only

Buttons: Cancel, Back, Communicate, Save and Exit, Save And Continue

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



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.



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

Service Counties

Selected Service County (By default, all services are certified for the county of your primary 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	LAKE

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 Provider Dashboard LaSalvia, Samantha

Getting Started Introduction Intent **More Information** Summary

50%

More Information

Disclosures

Are you a MBE (Minority Business Enterprise) Business?
 Yes No

Are you an EDGE (Encouraging Diversity, Growth, and Equity) business?
 Yes No

Are you currently or have you ever been an employer or employee at an agency serving individuals with developmental disabilities?
 Yes, I do have employment history at another DODD certified agency. No, I do not have employment history at another DODD certified agency.

Do you have a family member who provides or has provided services for DODD to a developmentally disabled person? "Relative" applies to your current or former spouse.
 Yes, I do have a relative who is/was certified. No, I do not have a relative who is/was certified

Do you have a business associate(s), who are or were certified to provide services through the Ohio Department of Developmental Disabilities (DODD)?
 Yes, I do have a business associate who is/was certified No, I do not have a business associate who is/was certified

If you have received your National Provider Identifier (NPI) number, please report it here.
NPI Number

If you had a previous National Provider Identifier (NPI) number, please report it here.
NPI Number

Summary

Name: Samantha LaSalvia
 Application Number: PROV-APP-75015
 Provider Type: Independent
 Application Type: Initial
 Status: Draft
 Start Date: 12/04/2017
 Fee Due : \$125.00
 ODM Fee Due : \$0.00
 Services
 • Shared Living

Save

Are you currently certified through the Ohio Department of Aging and/or the Ohio Department of Job and Family Services?
 Yes No

Enter all the languages you speak/write

Language	Start Date	End Date
ENGLISH	03/18/1988	12/31/2999

Have you lived outside the State of Ohio within the last 5 years (on or after 12/4/2012)?
 Yes, an FBI report is required. No, I have lived only within Ohio within the last 5 years.

Have you ever been indicted or convicted of a violation of State or Federal law? (Background for Investigations rule <http://dodd.ohio.gov/RulesLaws/Documents/5123-2-2-02%20Effective%202013-01-01.pdf>)
 Yes No

Please provide the Supplier ID assigned to you and your TIN (agency) or SSN (independent provider) by Ohio Shared Services Office of Budget and Management. (This is a 10 digit number, including any leading 0's.) If you already have a State of Ohio supplier number, please enter it here. Otherwise, new State of Ohio suppliers must first register online with the Ohio Office of Budget and Management (OBM) using the Supplier Self-Registration module of the Ohio Administrative Knowledge System (OAKS). Go to www.supplier.obm.ohio.gov and click 'Register a New Account'. Once you are assigned a Supplier Number, you will need to upload a copy of an email or screenshot of your account showing your name and assigned Supplier Number in the document upload below.

Summary

Name: Samantha LaSalvia

Application Number: PROV-APP-75015

Provider Type: Independent

Application Type: Initial

Status: Draft

Start Date: 12/04/2017

Fee Due : \$125.00

ODM Fee Due : \$0.00

Services

- Shared Living

Please provide the Supplier ID assigned to you and your TIN (agency) or SSN (independent provider) by Ohio Shared Services Office of Budget and Management. (This is a 10 digit number, including any leading 0's.) If you already have a State of Ohio supplier number, please enter it here. Otherwise, new State of Ohio suppliers must first register online with the Ohio Office of Budget and Management (OBM) using the Supplier Self-Registration module of the Ohio Administrative Knowledge System (OAKS). Go to www.supplier.obm.ohio.gov and click 'Register a New Account'. Once you are assigned a Supplier Number, you will need to upload a copy of an email or screenshot of your account showing your name and assigned Supplier Number in the document upload below.

Supplier ID *

* required

Save

Secondary Contacts

First Name	Last Name	Email	Phone
+ Add Secondary Contact			

RAPBACK

Pursuant to Administrative Code 5123:2-2-01, Providers must "consent to be enrolled in the Ohio attorney general's retained applicant fingerprint database ("Rapback")." Rapback is a criminal background check system. By initialing this consent and submitting your application, you are consenting to Rapback enrollment as part of your application processing.

I consent to enrollment by the Ohio Department of Developmental Disabilities in the Ohio attorney general's retained applicant fingerprint database (Rapback).

Independent Provider Initials*

Agree

Summary

Name: Samantha LaSalvia

Application Number: PROV-APP-75015

Provider Type: Independent

Application Type: Initial

Status: Draft

Start Date: 12/04/2017

Fee Due : \$125.00

ODM Fee Due : \$0.00

Services

- Shared Living

Documents

These documents are required in order to be an Ohio Medicaid Provider, and you cannot become certified until you have submitted these documents to the department. You must scan and upload the documents here to proceed with submitting your application.

BCII Background Checks cannot be uploaded to the Department. They must be mailed directly from the BCII office to the Ohio Department of Developmental Disabilities. This process can take up to 30 days, so please allow enough time for the Department to receive the document. When requesting your BCII, please use the following code for your reason fingerprinted:
BCII Code: 5123.169

Please have your BCII sent to the following address (only BCII's will be accepted through the mail):

The Ohio Department of Developmental Disabilities
Attention Provider Certification
30 E. Broad Street
13th Floor
Columbus, Ohio 43215

Max file size limit for upload is 75 MB and allowable file types are .doc, .docx, .pdf, .jpeg, .jpg, .tif, .tiff, .gif.

Please, ensure that all Required Documents have a corresponding Document Upload except the BCII and FBI, as listed

<input type="checkbox"/> 8 hour Initial Certification Training	<input type="checkbox"/> BCII Background Check
<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> CPR
<input type="checkbox"/> First Aid	<input type="checkbox"/> High School Diploma/GED
<input type="checkbox"/> Initial Overview	<input type="checkbox"/> OSS Verification of Supplier Number
<input type="checkbox"/> Social Security Number	<input type="checkbox"/> State of Ohio Identification
<input type="checkbox"/> W-9 Download W9	

Name: Samantha LaSalvia

Application Number: PROV-APP-75015

Provider Type: Independent

Application Type: Initial

Status: Draft

Start Date: 12/04/2017

Fee Due : \$125.00

ODM Fee Due : \$0.00

Services

- Shared Living

Attestations

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 direct services position must meet the following requirements. Furthermore, by initialing this page, you indicate your understanding and assurance to comply with the following requirements.

Applicant has read and understands the requirements of Ohio Administrative Code Chapter 5123.2. These rules can be found at: <http://dodd.ohio.gov/RulesLaws/Pages/RulesInEffect.aspx>

- Applicant will comply with the requirements of Ohio Administrative Code Chapter 5123.2.
- Applicant will comply with the requirements of all relevant state and federal statutes and state and federal rules.
- Applicant confirms that the information provided in this application is complete and accurate. Misrepresentations, false statements, inaccurate statements, or incomplete statements may result in a denial of the application or in the suspension or revocation of a provider's certification.
- In accordance with Executive Order 2011-03K, Applicant confirms: (1) it has reviewed and understands Executive Order 2011-03K, (2) it has reviewed and 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.

I accept the terms and conditions mentioned above.* [Print](#) [Email](#)

Applicant Initials*

[Agree](#)

Name: Samantha LaSalvia

Application Number: PROV-APP-75015

Provider Type: Independent

Application Type: Initial

Status: Draft

Start Date: 12/04/2017

Fee Due : \$125.00

ODM Fee Due : \$0.00

Services

- Shared Living

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:

Agree

Name: Samantha LaSalvia
 Application Number: PROV-APP-75015
 Provider Type: Independent
 Application Type: Initial
 Status: Draft
 Start Date: 12/04/2017
 Fee Due: \$125.00
 ODM Fee Due: \$0.00
 Services: Shared Living

Non Disclosure Agreement

Federal law;

- That the information may represent confidential personal information, protected health information, or proprietary information, the release or disclosure of which may be restricted or prohibited by state and federal law;
- That I shall regard all such information as confidential and that I shall not disclose, reveal, communicate, impart, or divulge the information or any summary or synopsis of the information in any manner or any form whatsoever;
- That DODD has instituted security measures designed to identify attempts to tamper with the websites, systems, operations, or procedures and that information collected through these security measures may be used in connection with a criminal prosecution or other legal proceedings;
- That DODD has instituted security measures designed to monitor and detect the unauthorized access or attempt to access information and that these security measures may result in the collection of information that may be used in connection with a criminal prosecution or other legal proceedings;
- That violation of any of these provisions may result in the cancellation of my security access and referral to the appropriate enforcement authorities.

By signing this statement, I acknowledge that I understand and agree to adhere to the limitations on access and disclosure described above.

Applicant Initials:

Agree

Medicaid Provider Agreement

This provider agreement is a contract between the Ohio Department of Medicaid (the Department) and the undersigned provider of medical assistance services in which the Provider agrees to comply with the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies to:

13. Comply with Section 6052 of the Deficit Reduction Act. This requirement applies to health care entities who receive Medicaid reimbursements of \$0,000,000 per year or more, to establish written policies for all their own employees and contractors to provide information about the False Claims Act, provide remedies for false claims, a description of false claims laws, whistleblower protections and detailed provisions for detecting and preventing fraud, waste and abuse.
14. Fully cooperate with the Department, its agents, and other state or federal 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. I further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive officer, or general partner of the business organization that 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, in 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

Agree

Cancel Back Communicate

Save and Exit Save And Continue

Once complete, select 'Save and Continue'

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

The screenshot shows a web application interface for a provider dashboard. The top navigation bar includes 'Home', 'Provider Dashboard', and the user name 'LaSalvia, Samantha'. Below the navigation bar is a progress indicator showing '50%' completion, with steps for 'Getting Started', 'Introduction', 'Intent', 'More Information', and 'Summary'. The 'More Information' section contains a list of required documents:

- Required disclosure text starting with "Please provide the Supplier ID assigned to you and your TIN (agency) or SSN (independent provider) b "
- Please attest Rapback for Independent Provider
- 8 hour Initial Certification Training document is required
- Birth Certificate document is required
- CPR document is required
- First Aid document is required
- High School Diploma/GED document is required
- Initial Overview document is required
- OSS Verification of Supplier Number document is required
- Social Security Number document is required
- State of Ohio Identification document is required
- W-9 document is required

The 'Disclosures' section contains the following questions and answers:

Are you a MBE (Minority Business Enterprise) Business?
 Yes No

Are you an EDGE (Encouraging Diversity, Growth, and Equity) business?
 Yes No

Are you currently or have you ever been an employer or employee at an agency serving individuals with developmental disabilities?
 Yes, I do have employment history at another DODD certified agency. No, I do not have employment history at another DODD certified agency.

Do you have a family member who provides or has provided services for DODD to a developmentally disabled person? "Relative" applies to your current or former spouse.
 Yes, I do have a relative who is/was certified. No, I do not have a relative who is/was certified

Do you have a business associate(s) who are or were certified to provide services through the Ohio Department of Developmental Disabilities (DODD)?

The 'Summary' sidebar on the right displays the following information:

- Name: Samantha LaSalvia
- Application Number: PROV-APP-75015
- Provider Type: Independent
- Application Type: Initial
- Status: Draft
- Start Date: 12/04/2017
- Fee Due: \$125.00
- ODM Fee Due: \$0.00
- Services: Shared Living

The Windows taskbar at the bottom shows the time as 9:00 AM on 12/4/2017.