APPLICATION FOR PROVIDER CERTIFICATION
AGED AND DISABLED WAIVER (A&D)
TRAUMATIC BRAIN INJURY WAIVER (TBI)
State Form 55512 (R3 / 12-22)

INSTRUCTIONS:
Complete the required documentation packet. Please visit http://www.in.gov/fssa/da/3476.htm for details.
Email the completed, signed and dated documents to daproviderapp@fssa.in.gov.

Date of application *(month, day, year)*	Type of application *(check one)* ☐ New application ☐ Change of ownership ☐ Add service(s)

Name of applicant

Telephone number ( )	Fax number ( )	E-mail address

Legal business name of applicant

Doing business as (DBA) name of applicant

Legal status of provider *(check one)*
☐ Individual / sole proprietor   ☐ Corporation   ☐ Partnership

Indiana State Department of Health (ISDH) license number	Name license issued to

Name of Chief Executive Officer (CEO) / administrator / owner

Name of contact person	Title

Physical location *(number and street, city, state, and ZIP code)*

Mailing address (*if different from above*) *(number and street or Post Office box, city, state, and ZIP code)*

Type of waiver in which you wish to provide services *(check all that apply)*
☐ Aged and Disabled (A&D) *(** indicates A&D only below)*   ☐ Traumatic Brain Injury (TBI) *(* indicates TBI only below)*

Service(s) you plan to provide *(check all that apply)*

☐ Adult Day Services
☐ Adult Family Care
☐ Assisted Living
☐ Attendant Care
☐ Behavior Management/Behavior Program and Counseling*
☐ Care Management
☐ Caregiver Coaching and Behavior Management**
☐ Community Transition
☐ Home and Community Assistance

☐ Home-Delivered Meals
☐ Home Modification Assessment**
☐ Home Modifications
☐ Integrated Health Care Coordination
☐ Nonmedical Transportation
☐ Nutritional Supplements
☐ Participant-Directed Home Care Service
☐ Personal Emergency Response System
☐ Pest Control

☐ Residential Based Habilitation*
☐ Respite Services
☐ Secure Memory Care Unit
☐ Specialized Medical Equipment and Supplies
☐ Structured Day Program*
☐ Structured Family Caregiving**
☐ Supported Employment*
☐ Vehicle Modifications

County(ies) in which you plan to provide service(s) *(check all that apply)*

☐ 01 Adams
☐ 02 Allen
☐ 03 Bartholomew
☐ 04 Benton
☐ 05 Blackford
☐ 06 Boone
☐ 07 Brown
☐ 08 Carroll
☐ 09 Cass
☐ 10 Clark
☐ 11 Clay
☐ 12 Clinton
☐ 13 Crawford
☐ 14 Daviess

☐ 15 Dearborn
☐ 16 Decatur
☐ 17 DeKalb
☐ 18 Delaware
☐ 19 Dubois
☐ 20 Elkhart
☐ 21 Fayette
☐ 22 Floyd
☐ 23 Fountain
☐ 24 Franklin
☐ 25 Fulton
☐ 26 Gibson
☐ 27 Grant
☐ 28 Greene

☐ 29 Hamilton
☐ 30 Hancock
☐ 31 Harrison
☐ 32 Hendricks
☐ 33 Henry
☐ 34 Howard
☐ 35 Huntington
☐ 36 Jackson
☐ 37 Jasper
☐ 38 Jay
☐ 39 Jefferson
☐ 40 Jennings
☐ 41 Johnson
☐ 42 Knox

☐ 43 Kosciusko
☐ 44 LaGrange
☐ 45 Lake
☐ 46 LaPorte
☐ 47 Lawrence
☐ 48 Madison
☐ 49 Marion
☐ 50 Marshall
☐ 51 Martin
☐ 52 Miami
☐ 53 Monroe
☐ 54 Montgomery
☐ 55 Morgan
☐ 56 Newton

☐ 57 Noble
☐ 58 Ohio
☐ 59 Orange
☐ 60 Owen
☐ 61 Parke
☐ 62 Perry
☐ 63 Pike
☐ 64 Porter
☐ 65 Posey
☐ 66 Pulaski
☐ 67 Putnam
☐ 68 Randolph
☐ 69 Ripley
☐ 70 Rush

☐ 71 St. Joseph
☐ 72 Scott
☐ 73 Shelby
☐ 74 Spencer
☐ 75 Starke
☐ 76 Steuben
☐ 77 Sullivan
☐ 78 Switzerland
☐ 79 Tippecanoe
☐ 80 Tipton
☐ 81 Union
☐ 82 Vanderburgh
☐ 83 Vermillion
☐ 84 Vigo

☐ 85 Wabash
☐ 86 Warren
☐ 87 Warrick
☐ 88 Washington
☐ 89 Wayne
☐ 90 Wells
☐ 91 White
☐ 92 Whitley
☐ State Wide

Please attach the following documents:

☐ 1. All required documents as specified in the provider requirements table located at https://www.in.gov/fssa/da/medicaid-hcbs/, direct link here; *https://www.in.gov/fssa/da/files/Service_specific_provider_requirements-July-1-2018.pdf*
☐ 2. W-9 Tax Identification Number
☐ 3. Secretary of State letter of authorization to conduct business in Indiana *(agencies only)*
☐ 4. Verification of liability insurance as required by 455 IAC 2-6-2, 455 IAC 2-12-1(4) (vehicle insurance), and 455 IAC 2-11-1 (property and personal Liability insurance)
☐ 5. Organizational Chart *(agencies only)*
☐ 6. Copy of Home Health Agency License or Personal Services Agency License *(if applicable)*

Have you read the following documents?

☐ 1. DA HCBS Waiver Provider Manual: https://www.in.gov/medicaid/providers/files/da-hcbs-waivers.pdf   ☐ Yes   ☐ No
☐ 2. The Aging Rule: http://www.in.gov/legislative/iac/T04550/A00020.PDF   ☐ Yes   ☐ No

Signature of authorized representative	Date *(month, day, year)*

Typed or printed name of authorized representative	Title