HIGH NEEDS SUPPORTS – POTENTIAL PROVIDER INTEREST FORM

NOTE: This is for information purposes only and is not meant to be a screening tool

DATE:	**ORGANIZATION NAME:**	**NPI # (if applicable):**
ADDRESS (Primary administrative office):		**EXECUTIVE DIRECTOR Name/Email:**
COUNTY:		**POINT OF CONTACT Name/Email:**

PROVIDER TYPE: *Please indicate any provider designations/licensure your agency maintains.*

☐ COMMUNITY SERVICE BOARD

☐ EMPLOYMENT SERVICE ORGANIZATION (ESO)

☐ NON-PROFIT ORGANIZATION

☐ BH PROVIDER

☐ DD PROVIDER

☐ SUD PROVIDER

☐ HOMELESS SERVICES PROVIDER

☐ PUBLIC HOUSING AUTHORITY

☐ Other (Please specify):

PROVIDER QUALIFICATIONS/EXPERIENCE (Please select all of the boxes that apply to your organization):	
☐ Currently a Medicaid billing agency *(Ex.DD provider or Community Living Provider)* ☐ Behavioral Health Licensure ☐ Supportive Housing/PSH Program Grantee or administrator ☐ Supported Employment CARF Accreditation ☐ Other relevant certification(s):	☐ Experience providing supportive housing (# of yrs.): ☐ Experience providing supported employment services (# of years): ☐ Other relevant experience(s):
Notes:	
SERVICES INTERESTED IN PROVIDING (Check all that apply): ☐ SUPPORTIVE HOUSING- Permanent Supportive Housing *(Services: Individual Housing and Pre-Tenancy, Individual Housing and Tenancy Sustaining and Community Transition Services)* ☐ SUPPORTED EMPLOYMENT* – Individual Placement and Support *(Services: Pre-Employment or Sustaining Employment Services)* *Excludes DD Waiver Services, see https://www.dmas.virginia.gov/for-providers/high-needs-support/ for information	
Notes:	
PROVIDER TECHNICAL ASSISTANCE: *Please indicate if you have received or are interested in receiving technical assistance. Note that the receipt of TA is not a prerequisite for participation in HNS. You may also indicate whether or not your agency would be interested in receiving TA for HNS services.* Supportive Housing TA received? Date of Most Recent Training: TA Provided by: Supported Employment TA received? Date of Most Recent Training: TA Provided by:	

Notes:

CURRENT PROVIDER ACTIVITY: *Provide the information requested for each service location your agency maintains. If you have more than three locations please include the remaining locations in a separate attachment (see last page for attachment).*

Service Location (see attachment to provide additional locations, if applicable):

Address:
Locality:

<u>Supported Employment</u>
# of FTEs providing services:

Average caseload ratio:

CARF Accreditation Type (ex. Employee planning services):

<u>Supportive Housing</u>
# of FTEs providing services:
Average caseload ratio:

Housing Activity:
☐ *Services only*
☐ *Housing unit only*
☐ *Housing voucher/subsidy/payment only*
☐ *Housing and Services – please specify:*

Number of provider owned/managed housing units at property, if applicable:

Specific eligibility criteria for access to housing units:
Income:
Population:
Referral Source/Service Type:

Notes:

EXISTING CONTRACTS: *Please provide information regarding any contractual relationships your agency currently maintains with the following entities. If applicable, please also specify whether or not your agency is currently accepting referrals for contracted services from these entities.*

MCOs:
☐ Anthem ☐ United Healthcare ☐ Virginia Premier ☐ Magellan ☐ Optima ☐ Aetna

Accepting MCO referrals?

BH Agency:
Specify:

Accepting BH Agency referrals? ☐ Yes ☐ No

Continuum of Care Member or Partner Organization (CoC): ☐ Yes ☐ No
Specify CoC Name:

Accepting CoC referrals? ☐ Yes ☐ No

Other Medicaid Payer(s): ☐ Yes ☐ No
Specify:

Accepting other Medicaid referrals? ☐ Yes ☐ No

Notes:

Attachment: Additional Service Sites

Service Location #: (add a number each site)

Address:

Supported Employment
# of FTEs providing services:

Average caseload ratio:

CARF Accreditation Type (ex. Employee planning services):

Supportive Housing
# of FTEs providing services:
Average caseload ratio:

Housing Activity:
☐ *Services only*
☐ *Housing unit only*
☐ *Housing voucher/subsidy/payment only*
☐ *Housing and Services – please specify:*

Number of provider owned/managed housing units at property:

Specific eligibility criteria for access to housing units:
Income:
Population:
Referral Source/Service Type: