 **West Virginia Department of Health and Human Resources**

**Agency Provider Expansion Application**

**Socially Necessary Services**

**Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Agency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Agency Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Identify the service(s) you wish to add and the county(ies) in which you will be providing these service. Please indicate all of the county(ies) in which services will be provided. If coverage includes the entire state, please indicate “Statewide.”**

|  |  |  |
| --- | --- | --- |
| **Services** | **Check All that Apply** | **County**  **List County Name(s)** |
| Adult Life Skills |  |  |
| Agency Transportation |  |  |
| Agency Transportation One |  |  |
| Agency Transportation Two |  |  |
| Agency Transportation Three |  |  |
| Public Transportation |  |  |
| Public Transportation One |  |  |
| Public Transportation Two |  |  |
| Public Transportation Three |  |  |
| Family Crisis Response |  |  |
| General Parenting |  |  |
| Home Maker Services |  |  |
| Individual Parenting |  |  |
| Intervention Travel Time |  |  |
| Transportation Time |  |  |
| Pre-Reunification Support |  |  |
| Private Transportation (Foster Care Agency Only) |  |  |
| Private Transportation One (Foster Care Agency Only) |  |  |
| Private Transportation Two (Foster Care Agency Only) |  |  |
| Private Transportation Three (Foster Care Agency Only) |  |  |
| Emergency Respite |  |  |
| Respite |  |  |
| Daily Respite |  |  |
| Crisis Respite |  |  |
| Safety Services |  |  |
| Supervised Visitation One |  |  |
| Supervised Visitation Two |  |  |
| Supervision |  |  |
| Meals (Biological Parents/Guardian & Foster Parents Only) |  |  |
| Lodging (Biological Parents/Guardian & Foster Parents Only) |  |  |
| MDT Attendance |  |  |
| Home Study |  |  |
| Tutoring |  |  |
| Connection Visit (Foster Care Agency Only) |  |  |
| Away from Supervision Support (Residential Providers Only) |  |  |
| Chafee Transitional Living (Foster Care Agency Only) |  |  |
| Chafee Pre-Placement (Foster Care Agency Only) |  |  |
| Agency Transportation – Chafee (Foster Care Agency Only) |  |  |
| Case Management (\*\* Special Approval Needed) |  |  |
| CAPS Family Assessment |  |  |
| CAPS Case Management Services |  |  |
| Family & Needs Assessment/Service Plan (\*\* Special Approval Needed) |  |  |

By signing below, you are verifying and certifying that your agency is familiar with the laws and regulations regarding the provision of Socially Necessary Services and that the services you provide are compliant with these laws and regulations.

You are also agreeing to the following:

* Enrolling to expansion of Socially Necessary Services and the services will be provided in the counties indicated on this document;
* Agree to adhere to the established guidelines set forth by the West Virginia Department of Health and Human Resources (DHHR), Bureau for Social Services (BSS) and the SNS Provider Agreement;
* Have properly credentialed staff members for providing these services who have reviewed the materials posted/enclosed;
* Will follow the established standard of documentation of service stated within the Utilization Management Guidelines at [https://dhhr.wv.gov/bss/Providers/Pages/Provider-Forms.aspx](https://dhhr.wv.gov/bcf/Providers/Pages/Provider-Forms.aspx);
* Provider and their employees will comply with BSS’s SNS Code of Conduct;
* Provider will comply with BSS’s SNS Provider Background Check Policy;
* Do not employ individuals who have been listed on the Health and Human Services Office of Inspector General’s list of Excluded Individuals/Entities (HH OIG LEIE).

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**