



Bureau for Social Services
HEALTHY FAMILIES AMERICA
AGENCY PROVIDER REQUEST FORM
Socially Necessary Services

Agency Name: _____ Provider # _____

Agency Contact Person: _____

Title: _____ Email: _____

Agency Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

If you are wishing to add a service, then check the “New Service” box for the designated service and include the county name(s) in which this service will be provided. If coverage includes the entire state, then designate the service as “Statewide.”

Service	ADD	County Where Service Provided <i>List County Name(s)</i>	REMOVE
HEALTHY FAMILIES AMERICA	<input type="checkbox"/>		<input type="checkbox"/>

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 become a provider of Socially Necessary Services and the services will be provided in the counties indicated on this application;
- Agree to adhere to the established guidelines set forth by the West Virginia Department of Health and Human Resources 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/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)

By completing this Agency Provider Enrollment Application for the provision of Socially Necessary Services (SNS), the agency will also be required to submit all required documentation specified below, to the Bureau for Social Services, Office of Children and Adult Services. Documentation that is indicated below that will be “available upon request or for reviews”, does not need to be submitted with the Enrollment Application, but must be available upon request.

1. Copy of current Business License(s);
2. Office Location(s);
3. Staff location(s);
4. Completed original W-9;
5. Organizational Chart for employees of the agency for Socially Necessary Services (specify job title for each employee listed);
6. Counties for which the Socially Necessary Services are delivered;
7. Target Services to be delivered (found in the Social Necessity Utilization Management (UM) Guidelines and attached to this Agreement) and individual to provide service;
8. The number of full time equivalents (FTEs) and part time equivalents for each position in each office; **(available upon request or for review)**
9. Copies of the DHHR’s SNS Provider Code of Conduct Statement signed by each employee and subcontractor; **(available upon request or for review)**
10. Copies of completed statement of criminal record for all staff and all subcontractors; **(available upon request or for review)**
11. Copies of verification of all criminal background checks completed for all staff and subcontractors;
12. Copies of verification of all APS/CPS Checks completed for all staff and subcontractors;
13. Copy of current valid driver’s license and current car insurance for individuals transporting children or families; **(available upon request or for review)**
14. Copies of resumes for key administrative and program staff; **(available upon request or for review)**, and
15. Copies of insurance policy, which verifies \$1,000,000 of coverage and that DHHR is an added as an insured.

Signature: _____ **Date:** _____