

Completing an Application for Certification as a DODD Independent Provider

PRIOR TO starting an application, be sure that you have all of the required documents for certification AND that you have registered for/obtained your NPI number. You cannot complete an application without your NPI number.

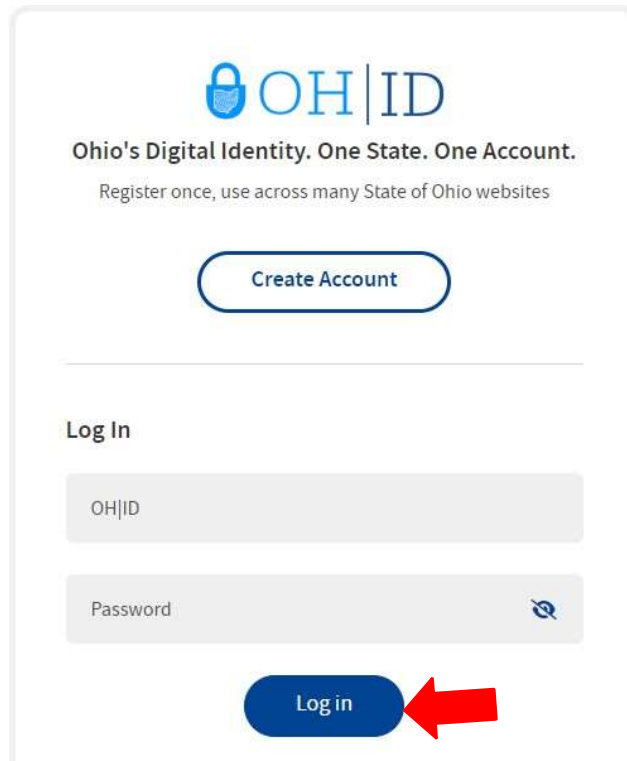
1. Access the PNM website

https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx

2. Click on the Log In with OH|ID button

3. Type in your OH|ID username and password, and click Log In.

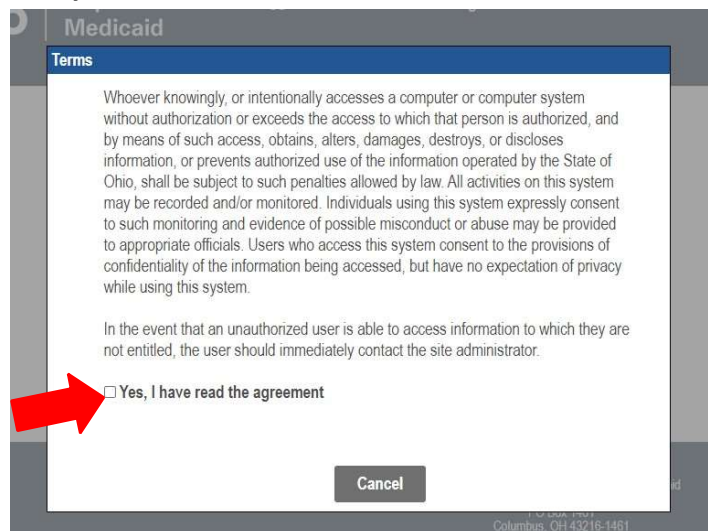
This is the same username you will use for Ohio Shared Services as well as once you become certified to access DODD systems



The image shows the OH|ID login interface. At the top is the OH|ID logo with the tagline "Ohio's Digital Identity. One State. One Account." and the instruction "Register once, use across many State of Ohio websites". Below this is a "Create Account" button. A horizontal line separates the registration section from the login section. The login section is titled "Log In" and contains two input fields: "OH|ID" and "Password". The "Password" field has a toggle icon for visibility. Below the input fields is a blue "Log in" button, which is highlighted by a red arrow pointing to it from the right.

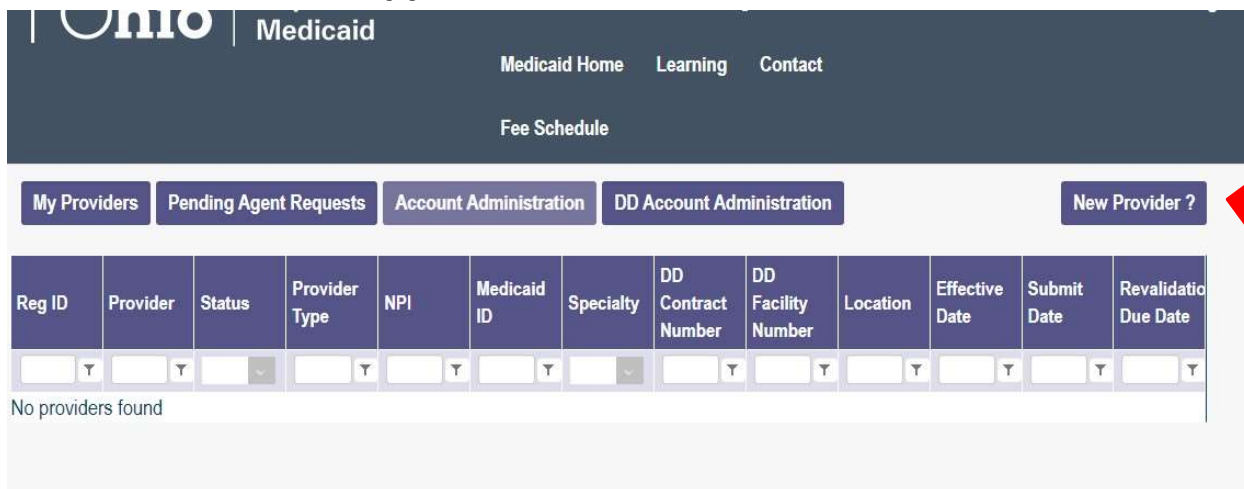
4. Click on Yes, I have read the agreement

Make sure that you have reviewed the information



The image shows a "Medicaid" Terms of Service dialog box. The title bar says "Medicaid" and the window title is "Terms". The text inside the dialog reads: "Whoever knowingly, or intentionally accesses a computer or computer system without authorization or exceeds the access to which that person is authorized, and by means of such access, obtains, alters, damages, destroys, or discloses information, or prevents authorized use of the information operated by the State of Ohio, shall be subject to such penalties allowed by law. All activities on this system may be recorded and/or monitored. Individuals using this system expressly consent to such monitoring and evidence of possible misconduct or abuse may be provided to appropriate officials. Users who access this system consent to the provisions of confidentiality of the information being accessed, but have no expectation of privacy while using this system." Below this text is another paragraph: "In the event that an unauthorized user is able to access information to which they are not entitled, the user should immediately contact the site administrator." At the bottom of the dialog is a checkbox labeled "Yes, I have read the agreement", which is highlighted by a red arrow pointing to it from the left. To the right of the checkbox is a "Cancel" button. At the very bottom of the window, there is small text: "Columbus, OH 43216-1461".

5. To start a new application, click on 'New Provider?'



Ohio Medicaid

Medicaid Home Learning Contact

Fee Schedule

My Providers Pending Agent Requests Account Administration DD Account Administration **New Provider ?**


Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date

No providers found


***** If there is NO New Provider button, please go to page 15 of these slides for directions.

6. Scroll down and click on 'Click here for more application types'

"Please note that you have 10 days to complete your application. After 10 days, your information will be removed and you will have to re-start the process from the beginning of the application."

Standard application	Ordering, Referring, Prescribing	Change of Operator	MCP Single Case
Use this application if you are applying to become a new individual, group, facility, or institutional provider to provide fee-for-service for the State Medicaid program.	Use this application if you are applying solely for the purpose of Ordering, Referring, or Prescribing.	Use this option if you want to initiate a Change of Operator for Skilled Nursing Facility or Intermediate Care Facility for individuals with intellectual disabilities.	Use this application if you are entering into a Single Case agreement with a Managed Care Plan.
Select	Select	Select	Select 

Click here for more application types...



7. From the menu, select 'Medicaid Waiver (DODD)'

The screenshot shows a menu with four options, each with a 'Select' button at the bottom. A red arrow points to the 'Medicaid Waiver (DODD)' option.

Medicaid Waiver (ODM)	Medicaid Waiver (ODA)	Medicaid Waiver (DODD)	Non-Medicaid DODD
Use this application if you are applying to become a Waiver Provider with Ohio Department of Medicaid.	Use this application if you are applying to become a Waiver Provider with Ohio Department of Aging or if you are initiating a Change of Ownership or Change of Operator as an ODA Provider.	Use this application if you are applying to become a Waiver Provider with Ohio Department of Developmental Disabilities.	Use this application if you are applying for one or more of the following options; Supported Living Service, Unpaid Support Broker, ICF Operators, or Licensees.
Select	Select	Select	Select

8. Choose Independent

The screenshot shows the 'Fee Schedule' form. The 'Application Type' is set to 'Waiver' with a 'Change' link. The 'Waiver Type' is set to 'Medicaid Waiver (DODD)'. Below these are two buttons: 'Independent' and 'Agency'. A red arrow points to the 'Independent' button.

Fee Schedule

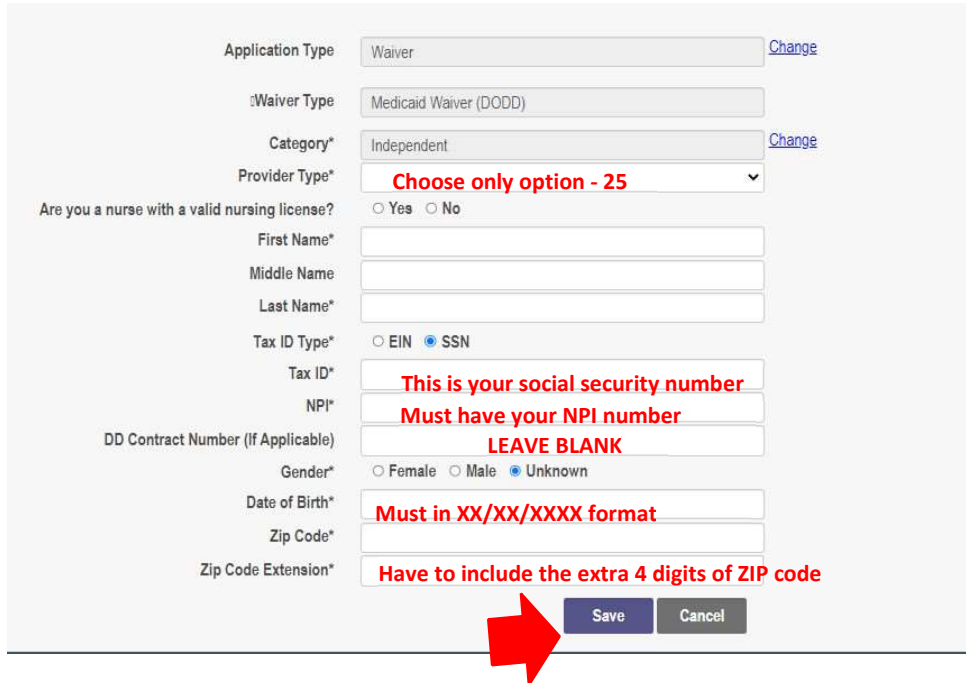
Application Type: Waiver [Change](#)

Waiver Type: Medicaid Waiver (DODD)

 Independent  Agency

9. Complete information on page and click Save *You MUST fill out everything with an **

A box for taxonomy will appear which auto populates based on the taxonomy code(s) you used when registering for your NPI. Choose the primary taxonomy you will use.

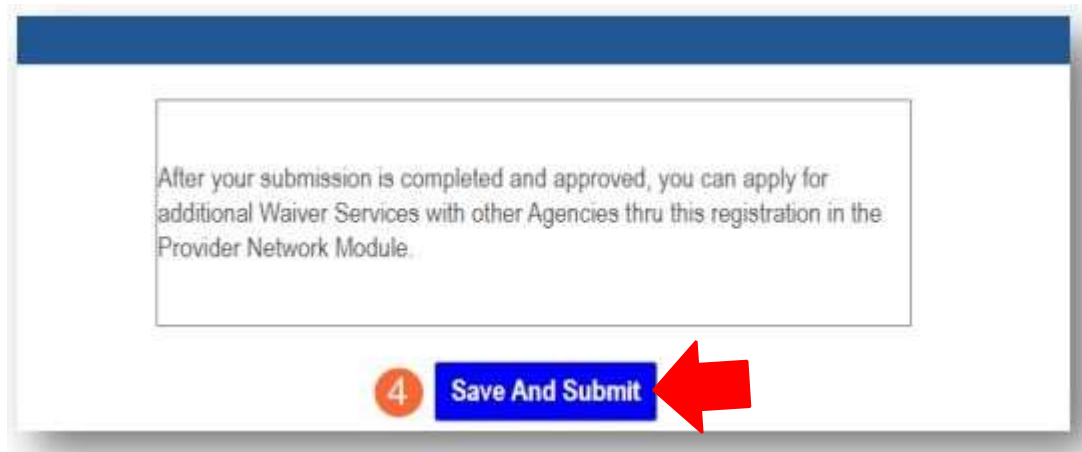


The form contains the following fields and instructions:

- Application Type: Waiver (with a [Change](#) link)
- Waiver Type: Medicaid Waiver (DODD)
- Category*: Independent (with a [Change](#) link)
- Provider Type*: Choose only option - 25 (dropdown menu)
- Are you a nurse with a valid nursing license?: ☐ Yes ☐ No
- First Name*, Middle Name, Last Name*: Text input fields
- Tax ID Type*: ☐ EIN ☒ SSN
- Tax ID*: This is your social security number
- NPI*: Must have your NPI number
- DD Contract Number (If Applicable): LEAVE BLANK
- Gender*: ☐ Female ☐ Male ☒ Unknown
- Date of Birth*: Must in XX/XX/XXXX format
- Zip Code*: Text input field
- Zip Code Extension*: Have to include the extra 4 digits of ZIP code
- Buttons: Save, Cancel

A red arrow points to the **Save** button.

10. Once complete, a confirmation will appear, click 'Save and Submit'



The confirmation screen displays the following text:

After your submission is completed and approved, you can apply for additional Waiver Services with other Agencies thru this registration in the Provider Network Module.

At the bottom, there is a blue button labeled **Save And Submit** next to a red circle containing the number 4. A red arrow points to the **Save And Submit** button.

11. Next, you will be transferred into the DODD PSM System to complete your application
12. Click on the Application Number in the table to access the DODD Application

Provider Dashboard [REDACTED]

Introduction

*The information pre populated below is based on data entered in PNM. If this information needs to be changed for any reason please select the Delete button to remove this application and log back into PNM to start a new application with the correct information.

Designation Type ?

☒ Provider

☐ Licensee

☐ Operator

Provider Type ?

☐ Agency ?

☒ Independent ?

☐ Unpaid Support Broker ?

10. Demographic information appears to be filled out.

You must include your NPI number in the NPI box. The Reg ID* number is already assigned and the box will already be filled in

<p>First Name*</p> <input type="text" value="[REDACTED]"/>	<p>Middle Initial</p> <input type="text"/>	<p>Last Name*</p> <input type="text" value="[REDACTED]"/>
<p>Gender*</p> <input type="text" value="[REDACTED]"/>	<p>Date of Birth*</p> <input type="text" value="[REDACTED]"/>	<p>Social Security Number*</p> <input type="text" value="[REDACTED]"/>
<p>City of Birth*</p> <input type="text" value="[REDACTED]"/>	<p>State of Birth*</p> <input type="text" value="[REDACTED]"/>	<p>Country of Birth*</p> <input type="text" value="[REDACTED]"/>
<p>Email*</p> <input type="text" value="[REDACTED]"/>	<p>Social Security Number Effective Date*</p> <input type="text" value="[REDACTED]"/>	

Cancel Back Communicate

Next

Save and Exit Save And Continue

11. Fill out the information, and check the boxes for home office, billing address, mailing address and alternative address if they are all the same. If you have alternative addresses for any of

those locations, do not click the box for it and fill out the applicable screen. Contact name is your name.

Phone 1* [Redacted] Extn [] Fax 1 [] Email* [Redacted]

Phone 2 [] Extn [] Fax 2 [] County* Select County v

Contact Name* []

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

- ☐ Home Office
- ☐ Billing and Payment
- ☐ Correspondence
- ☐ Alternative

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

13. On the next page, choose what service group applies to what you are applying for (typically waiver and non-waiver services), then click 'Save and Continue'

Home Provider Dashboard [Redacted]

Getting Started Introduction Intent More Information Summary

30%

Services

Choose Service Group

- ☐ Waiver & Non-Waiver Services ?
- ☐ Opportunities for Ohioans with Disabilities Provider Partner ?
- ☐ Non-Waiver services only ?

Cancel Back Communicate Save and Exit Save And Continue

Summary

Name: [Redacted]

Application Number: [Redacted]

Provider Type: [Redacted]

Application Type: [Redacted]

Status: [Redacted]

Start Date: [Redacted]

14. A list of service categories will appear. Click on the + sign in each category to expand it and find specific services.

15. Choose which services you are applying to be certified in. When choosing a service, a box will pop up describing the service. You must hit proceed to add it. Do this for every service you are applying to be certified to provide.

16. All selected services will be listed at the bottom of the page. Click 'Save and Continue' once you have added all services. Select **ALL** services you want to be certified in. There is a fee to add services once you are certified.

+ Respite or Long Term Care Services + Adult Day Services
 + Support Brokerage + County Board Services

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

Cancel Back Communicate Save and Exit **Save And Continue**

17. The More Information page will open including disclosures as well as the document upload portion of the application and the nondisclosure agreement and attestations.

Home Provider Dashboard [User Profile]

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

 Save

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

Summary

Name: [Redacted]
 Application Number: [Redacted]
 Provider Type: [Redacted]
 Application Type: [Redacted]
 Status: [Redacted]
 Start Date: [Redacted]
 Fee Due: [Redacted]
 ODM Fee Due: [Redacted]
 Services: Shared Living

Home Provider Dashboard

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: --Select-- Start Date: 12/4/2017

End Date: 12/4/2017

Add

Language	Start Date	End Date
ENGLISH		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: [REDACTED]
 Application Number: [REDACTED]
 Provider Type: [REDACTED]
 Application Type: [REDACTED]
 Status: [REDACTED]
 Start Date: [REDACTED]
 Fee Due: [REDACTED]
 ODM Fee Due: [REDACTED]
 Services: Shared Living

8:54 AM 12/4/2017

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 * [REDACTED]

* 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* [REDACTED]

Agree

Summary

Name: [REDACTED]
 Application Number: [REDACTED]
 Provider Type: [REDACTED]
 Application Type: [REDACTED]
 Status: [REDACTED]
 Start Date: [REDACTED]
 Fee Due: [REDACTED]
 ODM Fee Due: [REDACTED]
 Services: Shared Living

8:56 AM 12/4/2017

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

☐ 8 hour Initial Certification Training
 ☐ Birth Certificate
 ☐ First Aid
 ☐ Initial Overview
 ☐ Social Security Number
 ☐ W-9
 [Download W9](#)

☐ BCI Background Check
 ☐ CPR
 ☐ High School Diploma/GED
 ☐ OSS Verification of Supplier Number
 ☐ State of Ohio Identification

Name:

Application Number:

Provider Type:

Application Type:

Status:

Start Date:

Fee Due :

ODM Fee Due :

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.*

Applicant Initials*

[Print](#) [Email](#)

[Agree](#)

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:

Name:

Application Number:

Provider Type:

Application Type:

Status:

Start Date:

Fee Due :

ODM Fee Due :

Services

Shared Living

Non Disclosure Agreement

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 the limitations on access and disclosure described above.

Applicant Initials: [Redacted]

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 6002 of the Budget Reduction Act. This requirement applies to health care entities who receive Medicaid reimbursements of \$5,000,000 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 [Redacted Signature]

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 6002 of the Budget Reduction Act. This requirement applies to health care entities who receive Medicaid reimbursements of \$5,000,000 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 [Redacted Signature]

Agree

Save And Continue

When uploading documents, they must be done one at a time. Click the box of the document you are uploading, then upload the file containing that information. For items like CPR and First Aid, they may need to be uploaded twice to both categories

The application defaults to English as the language spoken/written. You only have to add languages if you speak/write anything in addition to English

18. Once complete, select 'Save and Continue'

19. If the application is complete, you will be able to review the application to ensure everything is correct and submit it.

Once you submit the application, you will be redirected to the payment page to pay your application fee.

If the page does not automatically redirect, you can access the payment page from the PSM-portal home page

20. If information is missing, this screen appears describing what is missing.

You will not be able to submit your application until you have all documentation and the application is complete. Be sure to upload all required information and fill in all required boxes.

Click Save and Exit to save the application as a draft to return to later.

The screenshot shows the 'More Information' step of an application process. A progress bar at the top indicates 50% completion. The 'More Information' section lists required documents: Required disclosure text, Rapback for Independent Provider, 8 hour Initial Certification Training document, Birth Certificate document, CPR document, First Aid document, High School Diploma/GED document, Initial Overview document, OSS Verification of Supplier Number document, Social Security Number document, State of Ohio Identification document, and W-9 document. Below this is a 'Disclosures' section with three questions, each with radio button options for Yes or No. The first question is 'Are you a MBE (Minority Business Enterprise) Business?'. The second is 'Are you an EDGE (Encouraging Diversity, Growth, and Equity) business?'. The third is 'Are you currently or have you ever been an employer or employee at an agency serving individuals with developmental disabilities?'. The fourth question is 'Do you have a family member who provides or has provided services for DODD to a developmentally disabled person?'. The fifth question is 'Do you have a relative who is/was certified?'. The sixth question is 'Do you have a business associate(s) who are or were certified to provide services through the Ohio Department of Developmental Disabilities (DODD)?'. A 'Summary' sidebar on the right shows fields for Name, Application Number, Provider Type, Application Type, Status, Start Date, Fee Due, ODM Fee Due, and Services (Shared Living).

Home Provider Dashboard

Getting Started Introduction Intent More Information Summary

50%

More Information

- 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

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)?

Summary

Name:

Application Number:

Provider Type:

Application Type:

Status:

Start Date:

Fee Due :

ODM Fee Due :

Services

- Shared Living

9:00 AM 12/4/2017

**** If you do not have a New Provider button please follow this step:

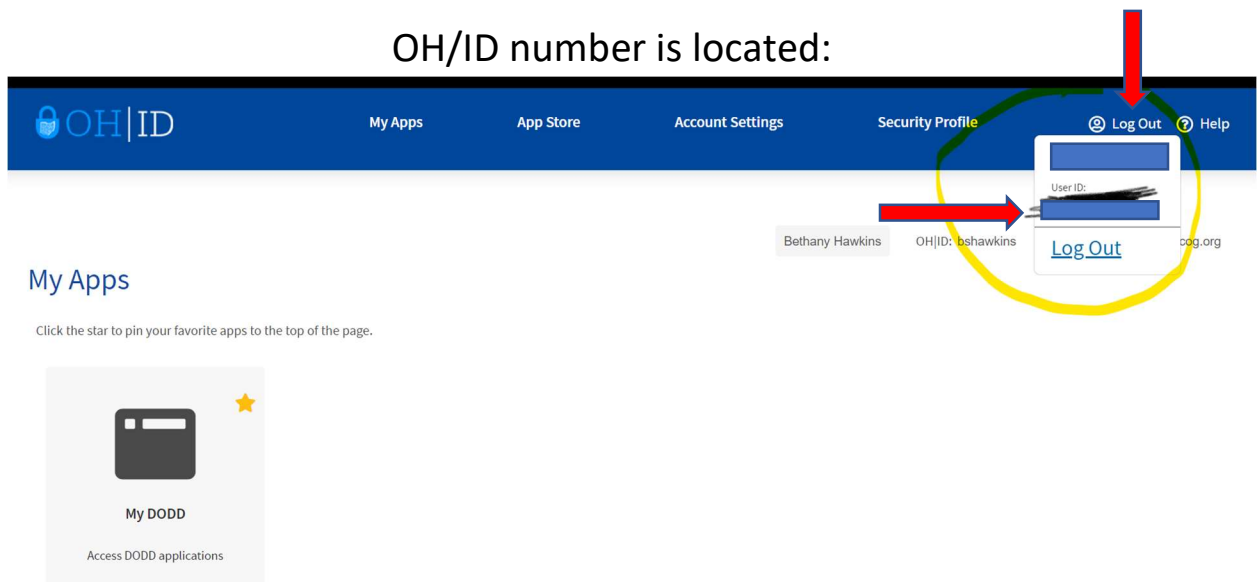
You will need to call PNM; they have to fix something on their end:

PNM/ODM (Ohio Dept of Medicaid) Helpdesk:

IHD@medicaid.ohio.gov / 1-800-686-1516

- Please note you will need to know your NPI number and possibly your OH/ID number.

OH/ID number is located:



Once PNM has fixed this, you can log back in - hit New Provider button and continue with step #6