THE MARYLAND HEALTHY KIDS/EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM
PROVIDER APPLICATION FOR CERTIFICATION & PARTICIPATION

Provider Name:___________________________ Group Name:__________________

Primary Address:___________________________________ Group #:________________

City:____________________________ State: _____ Zip: _________ County:________________

Specialty: ________________________ Ages Served: _____Contact Person: ________________

Telephone:______- ________Fax:______ - __________E-mail:__________________

MCO Participation (specify each MCO): _____________/ ____________/_____________/_______________

I. PROVIDER QUALIFICATIONS (Check all that apply):

( ) National Provider Identifier (NPI):_______________________________

( ) Currently participate in the Maryland Medical Assistance Program; provider number:_________________

( ) Currently participate with one or more Medicaid MCOs; MCO number (if not MA #)________________

( ) License number(s):_________________ Specify state(s) _______________

Provider shall meet one of the following requirements: (specify)

( ) Be board-certified, (circle specialty) pediatrics, family practice, internal medicine;

( ) Be a licensed physician or osteopath, or certified nurse practitioner, or physician assistant delivering primary health care to children and adolescents;

( ) Be a local health department or free standing clinic.

II. CONDITIONS FOR PARTICIPATION

All providers rendering preventive screening services to children must meet the following conditions, which are specified in the Maryland Healthy Kids/EPSDT Program regulations (COMAR 10.09.23) and Program policies:

(1) Provide or ensure the provision of the full set of screening procedures as outlined in the Healthy .ids 6FKHGXOH RI 3UHYHQWLY
DQGLQ D PDQQHU SUHVFULEHG E\ WKH 'HSDUWPHQW LQ WKH +HDOWK\ .LGV 3URYLGHU 0

3URYLGH LQWHU SHULRGLF DQG IXOO VFUHHQLQJ DV GHHPHG PHGLFDOO\ QHFHVVDU

3URYLGH RU DUUDQJH IRU D UHIHUUDOV IRU GLDJQRVLV WUHDWPHQW DQG IROOR
EDFXWH DQG WHUWLDU\ FDUH F ORQJ WHUP DQG UHKDELOLWDWLYH FDUH DQG G UH

,QIRUP WKH SDUHQW RU JXDUGLDQ RI WKH QHHG IRU SUHYHQWLYH KHDOWK FDUH YL
DSSRLQWPHQW DQG IDFLOLWDWH DGKHUHQFH WR WKH SHULRGLFLW\ VFKHGXOH 6FKHGXOH RI

(5) Agree to cooperate with state and local health department efforts to assure that children receive QHHGHG IROORZ XS DQG WU
7KLV UHTXLUHV UHIHUUDOV WR WKH ORFDO KHDOWK GHSDUWPHQWV ZKHQ DSSURSULDWH
LPPXQL]DWLRQ DSSRLQWPHQWV

THE MARYLAND HEALTHY KIDS/EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM PROVIDER APPLICATION FOR CERTIFICATION & PARTICIPATION

(6) Maintain a physical location where the full array of EPSDT screening and preventive health services are delivered;

(7) Maintain a patient record system that is sufficiently detailed and current to allow another provider who is unfamiliar with the patient to properly continue treatment in the absence of the primary care provider. Additionally, the record must sufficiently document the preventive screening components in accordance with the Healthy Kids Schedule of Preventive Health Care;

(8) Agree to on-site visits by the State program staff that will:

- ➢ Verify provider qualifications,
- ➢ Assess the need for provider/staff training, technical assistance, or in-service training,
- ➢ Determine if equipment necessary to perform required procedures is available, functioning and being properly used,
- ➢ Review/audit Medical Assistance recipient charts to determine if the program standards are being met, if quality and quantity of child health services delivered is sufficient, and if appropriate referral and treatment services are adequately provided;

(9) Agree to participate in the Vaccines for Children (VFC) Program to assure that needed vaccines are readily available to the Medicaid enrollee according to the currently recommended Immunization Schedule, and

(10) Agree to cooperate with Department efforts to provide timely access for all child health services including services for children with special needs and children in state supervised care.

PROVIDER AGREEMENT

I ____________________________________(print name) agree to comply with requirement listed in Section II Conditions for Participation and understand I may be granted a provisional certification upon review of my application. I also understand that I may receive full certification status only after the completion of an on-site review.

Signature:_______________________________________ Date:________________

DEPARTMENT CERTIFICATION

This provider meets the provider qualification requirements and conditions for participation listed in Sections I and II.

Full Certification granted on (date):____________

EPSDT Program Nurse Consultant Signature: ______________

Return Address: DHMH – Unit 79
Healthy Kids Program, Division of Children’s Service
201 W. Preston Street, Room 210
Baltimore, MD 21201
FAX: 410-333-5426