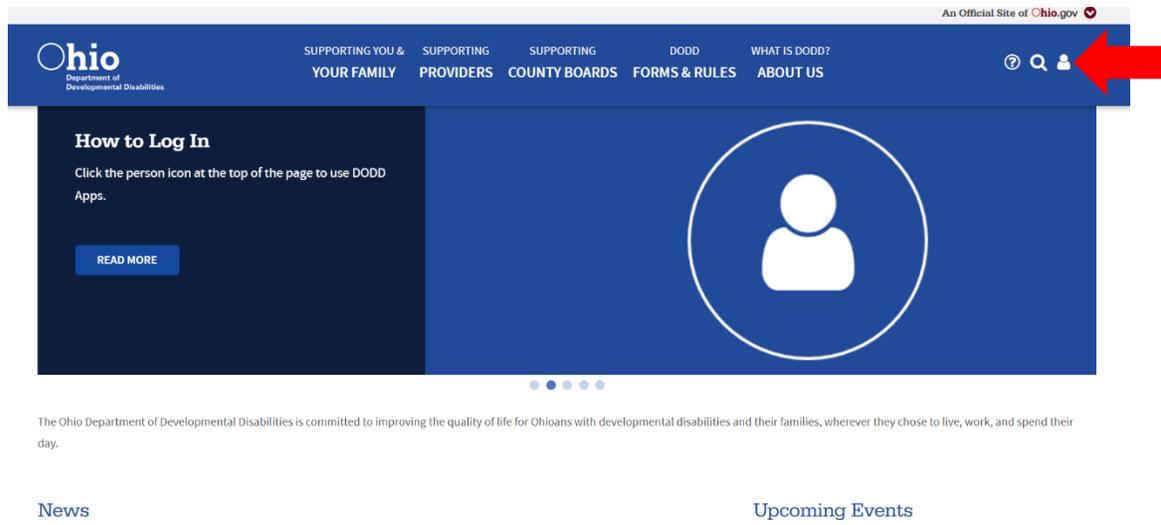


Accessing and Using DODD's Provider Services Management (PSM) System to Apply for Certification

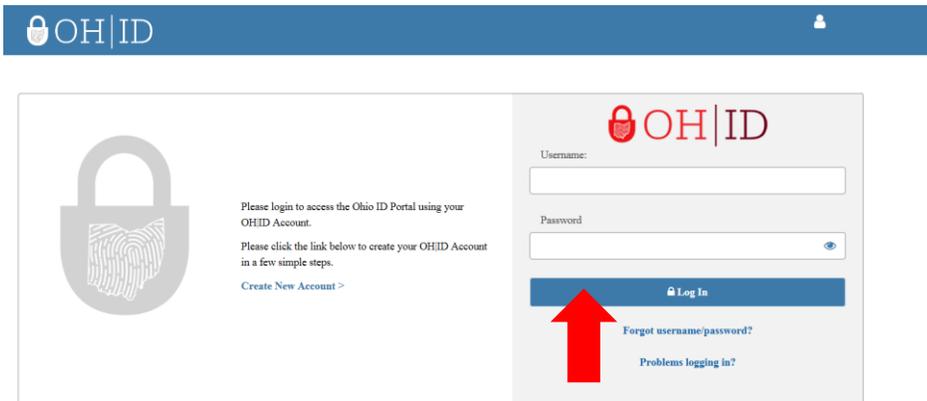
1. Access the DODD website

Go to <https://dodd.ohio.gov/Pages/default.aspx>

2. Click on the Log In icon on the top right of the page



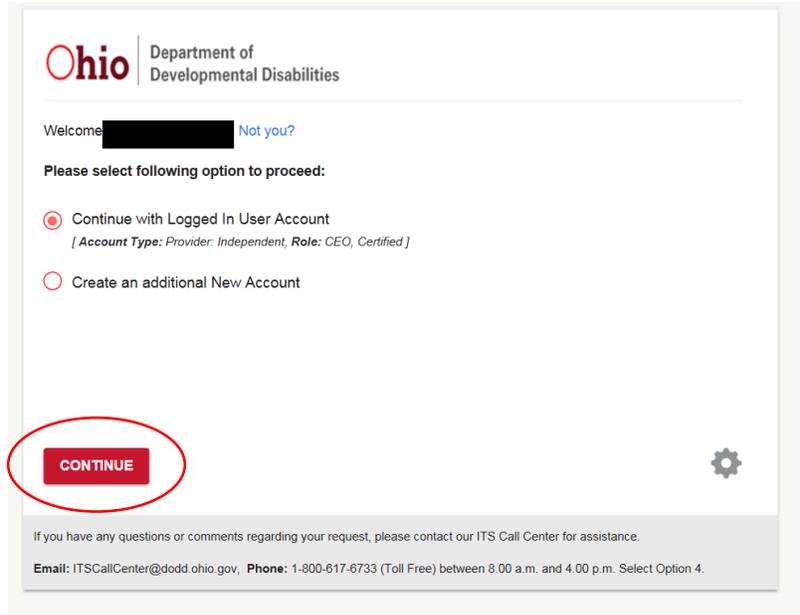
3. Type in your DODD username and password, and click Log In.



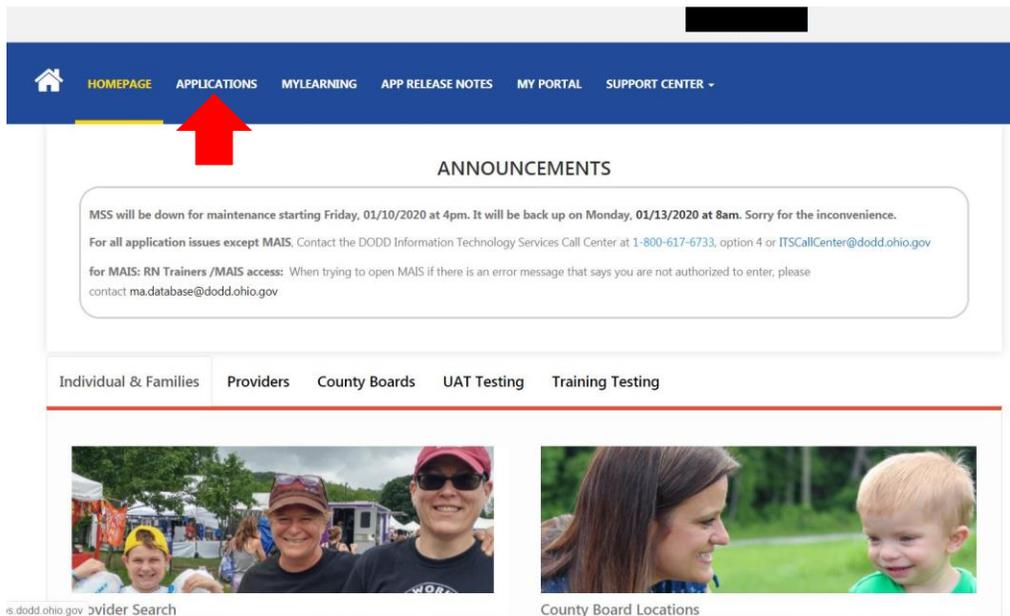
State of Ohio computer systems may be accessed and used only for official state business by authorized personnel. Unauthorized access or use of these computer systems may subject violators to criminal, civil, and/or administrative action.

4. Click on Continue when this screen appears

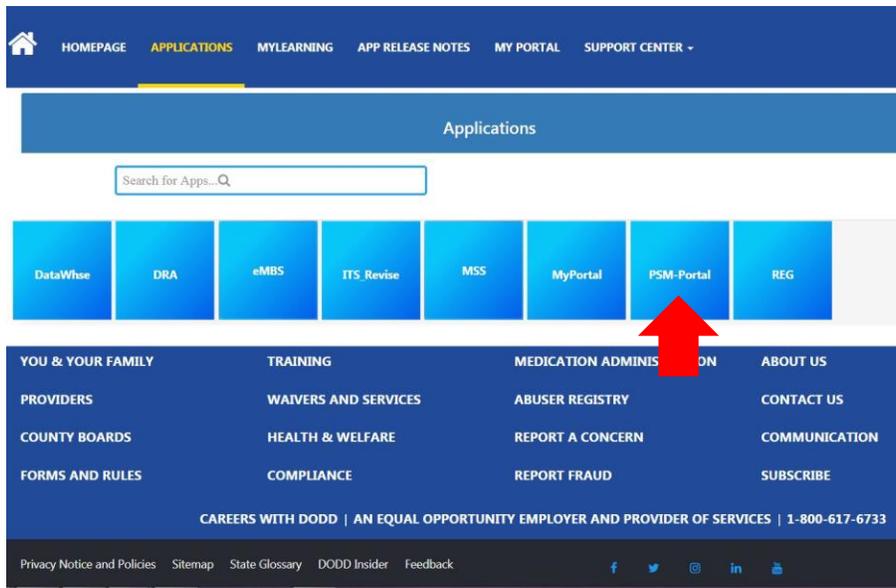
Make sure that the selected information on the screen is correct



5. Once you are logged in, click on applications

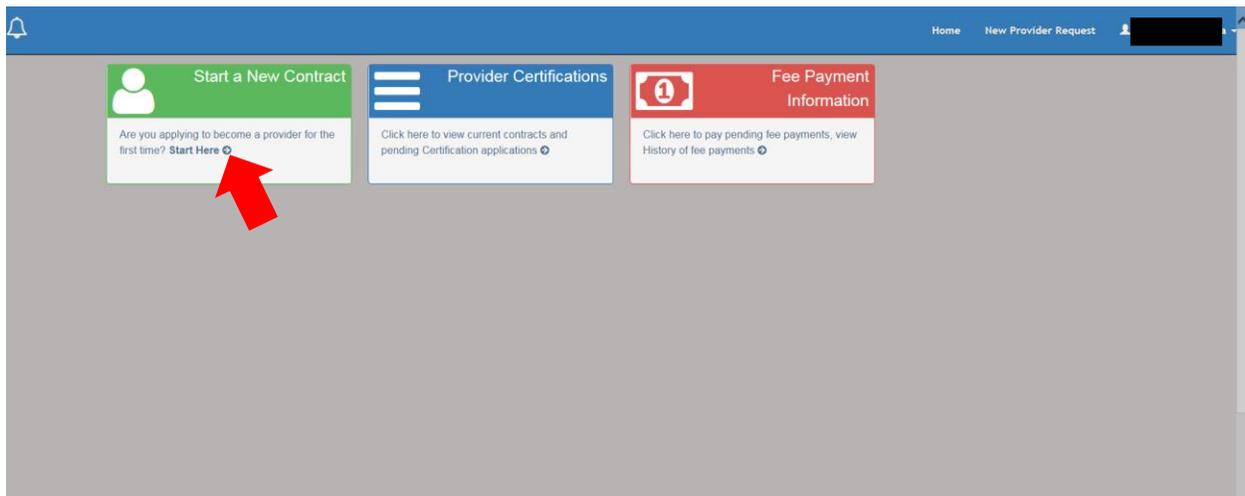


6. From the menu, select PSM-portal



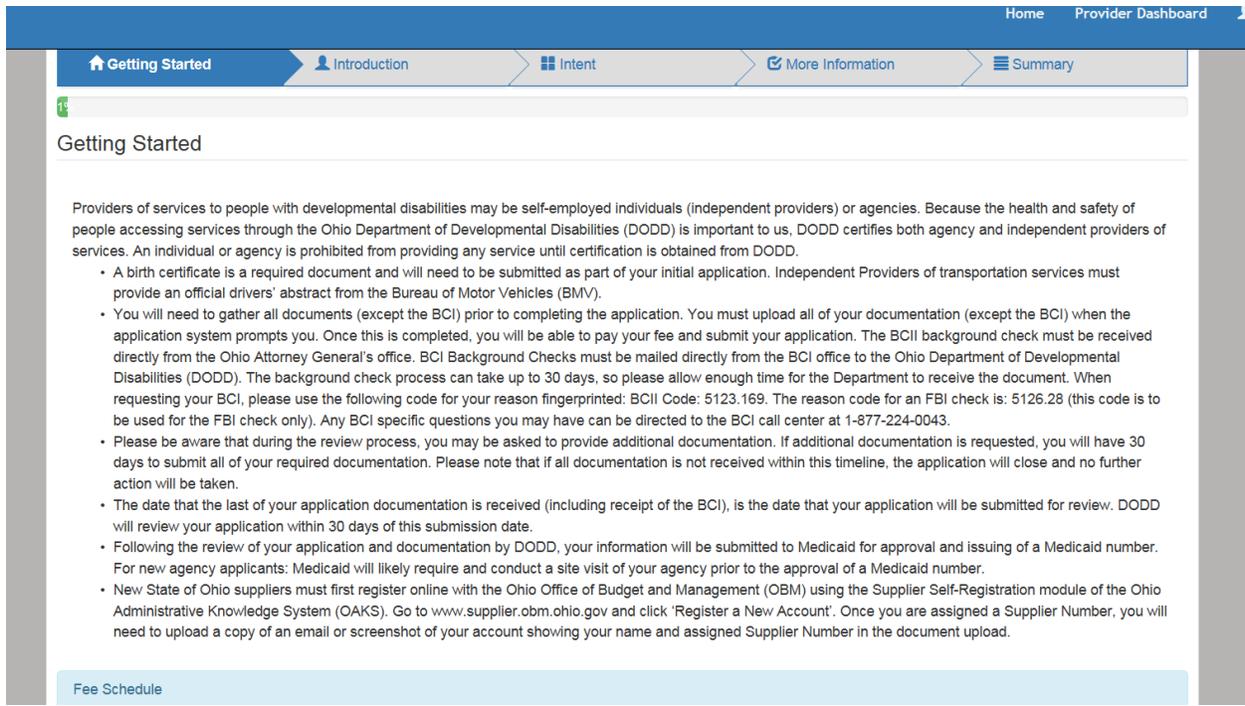
7. To start a new application in the PSM-portal, click on the arrow in the green box (Start a New Contract).

If you already have a draft application previously started, click the arrow in the first blue box (Provider Certifications)

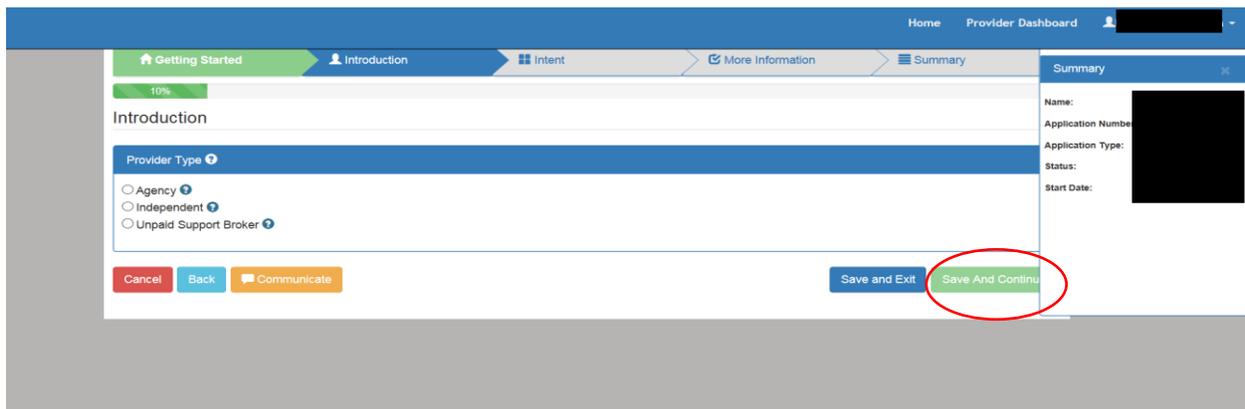


8. When starting a new application, the following screen opens. There is also a list of all the fees. At the bottom click on 'Continue' to get to the next page.

Make sure you understand all the information in the application



9. The introduction page appears. Choose which type of provider you are applying for then click Save and Continue.



10. Demographic information appears to be filled out. You must first fill out the Search for Existing Demographic Information box and click search prior to filling out the remainder of the screen.

The screenshot shows the 'Introduction' step of a registration process. The 'Provider Type' section has 'Independent' selected. The 'Independent Provider Demographics' section contains a 'Search for Existing Demographic Information' box with a red circle around the 'Search' button. Below this are fields for 'First Name*', 'Middle Initial', 'Last Name*', 'Gender*', and 'Date of Birth*'. A progress bar at the top shows 10% completion. A 'Summary' sidebar is visible on the right.

This screenshot shows the continuation of the 'Independent Provider Demographics' form. The 'Next' button at the bottom right is circled in red. The form includes fields for 'First Name*', 'Middle Initial', 'Last Name*', 'Gender*', 'City of Birth*', 'State of Birth*', 'Country of Birth*', 'Email*', and 'Social Security Number Effective Date*'. At the bottom, there are buttons for 'Cancel', 'Back', 'Communicate', 'Save and Exit', and 'Save And Continue'.

11. Click Next. 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.

Primary Service Location

First Name* Middle Initial Last Name*

Building Name

Address Line 1* Address Line 2

City* State* Zip* Zip4

Phone 1* Extn Fax 1 Email*

Phone 2 Extn Fax 2 County*

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

Home Office Billing Address Mailing Address

Alternative Address

Home Office

First Name* Middle Initial Last Name*

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'

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:

Application Number:

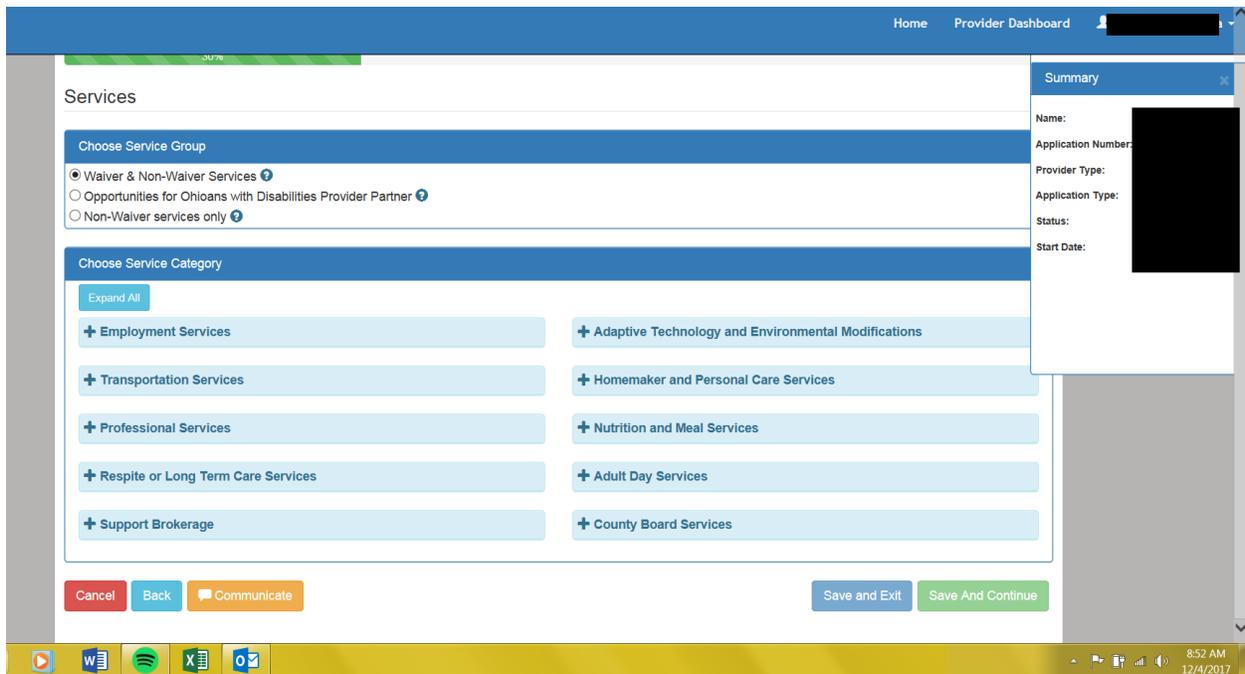
Provider Type:

Application Type:

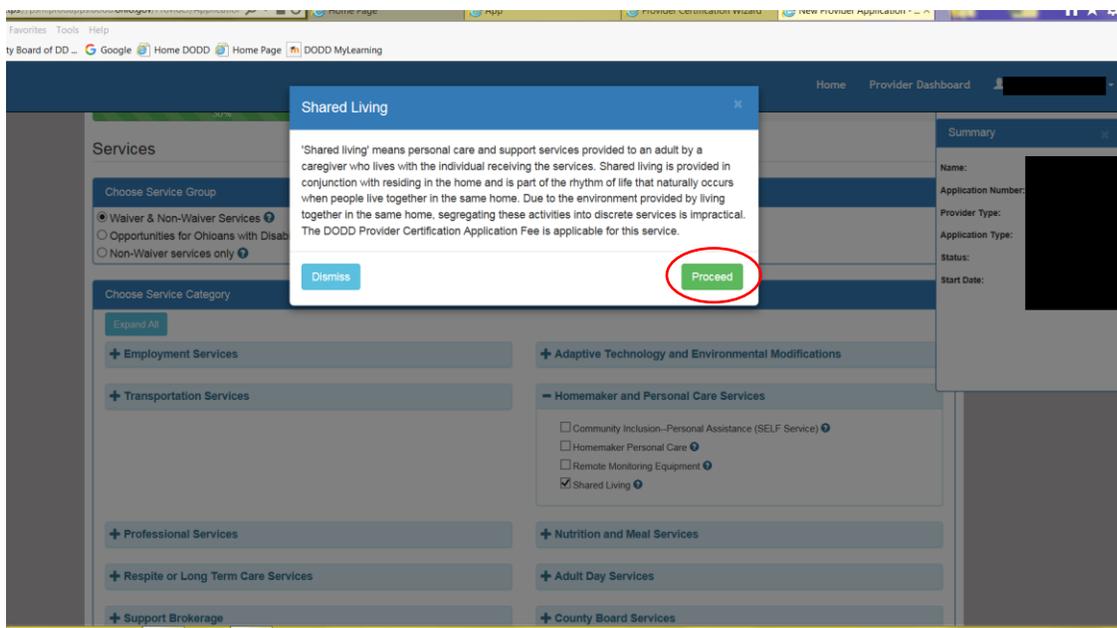
Status:

Start Date:

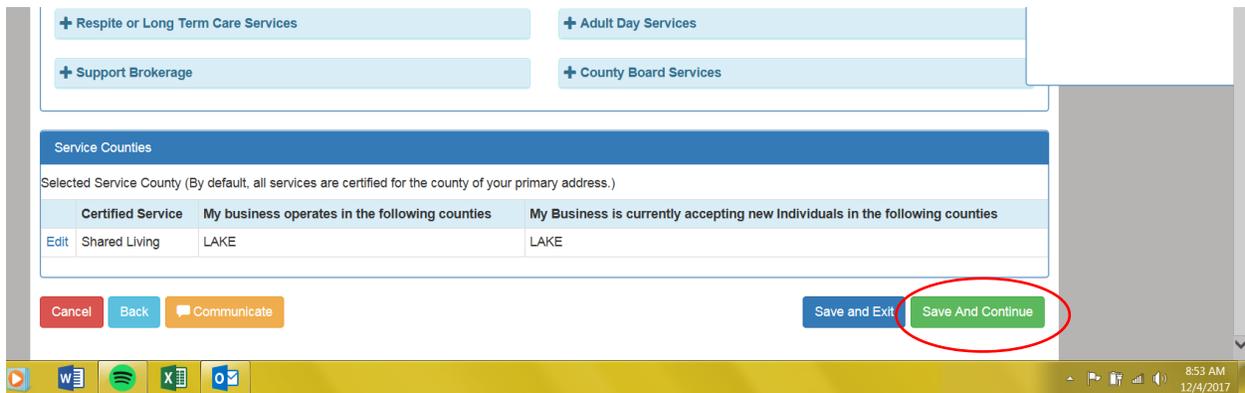
14. A list of service categories will appear. Click on the + sign in each category to expand it and find specific services.



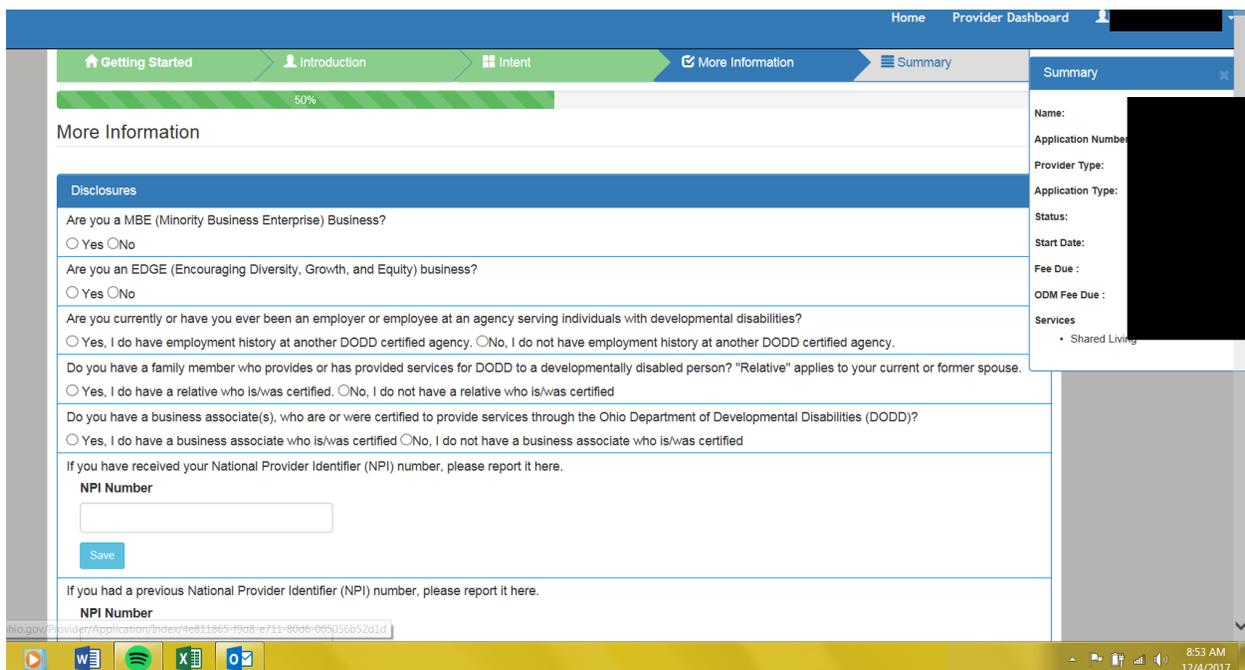
15. Choose which services you are applying to be certified in. When choosing a service, a box will pop up describing the service. You must hit proceed to add it. Do this for every service you are applying to be certified to provide.



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.



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.



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	Start Date
--Select--	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

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 initiating 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

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, .tig, .png, .txt, .tif, .tiff, .gif.

Please, ensure that all Required Documents have a corresponding Document Upload except the BCII and FBI, as listed

<input type="checkbox"/> 8 hour Initial Certification Training	<input type="checkbox"/> BCII Background Check
<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> CPR
<input type="checkbox"/> First Aid	<input type="checkbox"/> High School Diploma/GED
<input type="checkbox"/> Initial Overview	<input type="checkbox"/> OSS Verification of Supplier Number
<input type="checkbox"/> Social Security Number	<input type="checkbox"/> State of Ohio Identification
<input type="checkbox"/> W-9 Download W9	

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

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.* [Print](#) [Email](#)

Applicant Initials*

Agree

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

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:

Non Disclosure Agreement

Federal law;

- 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 adhere to the limitations on access and disclosure described above.

Applicant Initials

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 \$0,000,000 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

Name:

Application Number:

Provider Type:

Application Type:

Status:

Start Date:

Fee Due :

ODM Fee Due :

Services

- Shared Living

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 \$0,000,000 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

Name:

Application Number:

Provider Type:

Application Type:

Status:

Start Date:

Fee Due :

ODM Fee Due :

Services

- Shared Living

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 a web application interface for a provider dashboard. The top navigation bar includes 'Home', 'Provider Dashboard', and a user profile icon. Below the navigation bar is a progress indicator showing 50% completion, with steps: 'Getting Started', 'Introduction', 'Intent', 'More Information' (current step), and 'Summary'. The main content area is titled 'More Information' and contains a list of required documents:

- 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

Below the list is a 'Disclosures' section with the following questions and radio button options:

- 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)?

A 'Summary' sidebar is visible on the right, showing fields for Name, Application Number, Provider Type, Application Type, Status, Start Date, Fee Due, ODM Fee Due, and Services (Shared Living). The Windows taskbar at the bottom shows the date as 12/4/2017 and the time as 9:00 AM.