Independent Practitioner Services for Individuals with Developmental Disabilities

Clinician Application for OPWDD Approval

Background: Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD) is a new Medicaid State Plan service that consists of clinical services identified in Subpart 635-13 of14 NYCRR provided on and after April 1, 2016. IPSIDD services are limited to physical, occupational, and speech therapy; social work; and psychology services that may be provided to individuals in service arrangements subject to prior authorization from OPWDD. Independent practitioners must meet the qualifications specified in subdivision 635-13.3 in order to provide and receive reimbursement from Medicaid for IPSIDD. Specifically, to provide and bill for IPSIDD the provider must be a clinician licensed in New York State:

(i) whose name and credentials have been submitted to OPWDD; and
(ii) who has had specialized training in intellectual/developmental disabilities; and
(iii) who has had 2 years of experience treating individuals with intellectual/developmental disabilities; and
(iv) who has received approval from OPWDD to provide IPSIDD services to those individuals who meet the required eligibility criteria.

This application form should be completed by NYS licensed clinicians who meet the regulatory requirements and who wish to provide services and receive reimbursement for IPSIDD services.

Instructions to applicant: Please complete application and submit along with supporting documentation to OPWDD at: **IPSIDD.Applications@opwdd.ny.gov**

NAME (last, first, middle initial) ____

License/Certification Number ______________________________ Expiration Date___________

National Provider Identification Number____

Discipline (check one)

___Physical Therapist ___Occupational Therapist

___Speech/Language Pathologist ___Licensed Clinical Social Worker

___Licensed Psychologist

Mailing Address

____

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Phone Number (work)_______________________ (home/cell) ___________________________

Email address ____

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1. **Attach** a brief description of any specialized training you have received related to serving individuals with intellectual/developmental disabilities (I/DD).

2. Do you have two years of experience serving individuals with I/DD in the United States?

   ___Yes ___No

   Attach a brief description of your experience serving individuals with I/DD, including the length of time providing services. Specify any agency providing services to individuals with I/DD with which you have had an affiliation.

3. Have you ever been found guilty of or been subject to a disciplinary action by the Board of Regents for professional misconduct, or are you currently under investigation or are proceedings pending by this body?

   ___Yes (**attach detailed explanation**) ___No

4. **Attach** your resume. Please make sure that your education/degree is included and that you have clearly illustrated how you have met the aforementioned qualifications.

NOTE: OPWDD reserves the right to contact current and previous employers and affiliated agencies to verify any and all information provided in this application.

Attestation:
I attest that, to the best of my knowledge, all information provided by me on this form is true as of the date of my signature below.

____
Print Name

____ __________________
Signature Date

State of New York
ss:
County of (____________________)

On the_______ day of_______ in the year_______ before me,
the undersigned, personally appeared____________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

State of New York

County of ___________

Subscribed to and sworn before me this ________ day of __________(month), _______(year),

by ____________________ (name of signer)

_____________________ (signature of notary) (seal of notary)

OPWDD Use Only

Name of Applicant (last, first, middle initial) ____

Date application received at OPWDD Central Office _________________________________

Name of OPWDD Staff reviewing application _____________________________________

Email ____

Phone Number ____

Item	**Date Completed**	**Comments**
Application/Resume Review		
Verification of Current License Check for professional misconduct/disciplinary action(s)		
Reference Checks		

Step One Review

OPWDD Central Office Recommendation:

___Approved ___Not Approved

____ ________________

Signature of OPWDD Staff Reviewer Date

Step Two Review (if applicable)

Commissioner Review (if not approved at Step One)

___Approved ___Not Approved

____ _______________

Signature of Commissioner/Designee Date