



Kepro
 WV I/DD Waiver CareConnection©
 Provider Registration Form

The CareConnection© Provider Registration Form must be submitted in its entirety to your KEPRO assigned Provider Educator to initiate provider registration to receive I/DD Waiver authorizations. It is recommended that the CEO/Responsible Officer and Waiver Contact designations be two separate persons.

Please Type or Print Clearly | *Required Field

CEO/Responsible Officer			
First Name*	Middle Initial	Last Name*	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email Address*	Phone Number*	Fax Number*	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Address 1*			
<input type="text"/>			
Address 2			
<input type="text"/>			
City*	State*	Zip Code*	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

I/DD Waiver Contact Person			
First Name*	Middle Initial	Last Name*	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email Address*	Phone Number*	Fax Number*	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Address 1*			
<input type="text"/>			
Address 2			
<input type="text"/>			
City*	State*	Zip Code*	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Provider Company Information		
Provider Name* (include location/city-example: CCIL-Beckley)		
<input type="text"/>		
Provider Number* (Behavioral Health License #)		
<input type="text"/>		
Agency Address*		
<input type="text"/>		
Agency Address 2		
<input type="text"/>		
City*	State*	Zip Code*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone*	Fax*	WV Medicaid Provider Number*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Web Address	National Provider Identifier	
<input type="text"/>	<input type="text"/>	

I/DD Waiver Provider Counties and Services Designation*

	Ext Prof Svcs		IPP Planning		Trans	EAA	Nursing		SC	BSP/TC		Direct Support Svcs																	
	Speech Therapy	Occupational Therapy	Physical Therapy	Dietary Therapy	Skilled Nursing - RN- IPP Planning	Behavior Support Professional I-IPP Planning	Behavior Support Professional II- IPP Planning	Transportation-Trips	Transportation-Miles	Environmental Accessibility	Skilled Nursing-RN	Skilled Nursing-LPN	Service Coordination	Behavior Support Professional I	BehaviorSupport Professional II	Facility-Based Day Habilitation	Pre-Vocational Services	Job Development	Supported Employment	Family Person-Centered Support	Home-Based Person-Centered Support	Licensed Group Home Person-Centered Support	Unlicensed Residential Person-Centered Support	Crisis Site Person-Centered Support	In-Home Respite	Out-of-Home Respite	Crisis Services	Electronic Monitoring/Surveillance	Personal Options Services
ALL COUNTIES																													
1 Barbour																													
2 Berkeley																													
3 Boone																													
4 Braxton																													
5 Brooke																													
6 Cabell																													
7 Calhoun																													
8 Clay																													
9 Doddridge																													
10 Fayette																													
11 Gilmer																													
12 Grant																													
13 Greenbrier																													
14 Hampshire																													
15 Hancock																													
16 Hardy																													
17 Harrison																													
18 Jackson																													
19 Jefferson																													
20 Kanawha																													
21 Lewis																													
22 Lincoln																													
23 Logan																													
24 McDowell																													
25 Marion																													
26 Marshall																													
27 Mason																													
28 Mercer																													
29 Mineral																													
30 Mingo																													
31 Monongalia																													
32 Monroe																													
33 Morgan																													

I/DD Waiver Provider Counties and Services Designation (cont.)

	Ext Prof Svcs		IPP Planning		Trans	EAA	Nursing		SC	BSP		Direct Support Svcs														
	Speech Therapy	Occupational Therapy	Physical Therapy	Dietary Therapy			Skilled Nursing - RN- IPP Planning	Behavior Support Professional I-IPP Planning		Behavior Support Professional II-IPP Planning	Transportation-Trips	Transportation-Miles	Environmental Accessibility	Skilled Nursing-RN	Skilled Nursing-LPN	Service Coordination	Behavior Support Professional I	Behavior Support Professional II	Supported Employment							Electronic Monitoring/Surveillance
34 Nicholas																										
35 Ohio																										
36 Pendleton																										
37 Pleasants																										
38 Pocahontas																										
39 Preston																										
40 Putnam																										
41 Raleigh																										
42 Randolph																										
43 Ritchie																										
44 Roane																										
45 Summers																										
46 Taylor																										
47 Tucker																										
48 Tyler																										
49 Upshur																										
50 Wayne																										
51 Webster																										
52 Wetzel																										
53 Wirt																										
54 Wood																										
55 Wyoming																										

CEO/Responsible Officer Certification

I certify that the information provided on this form is accurate and reflects the services the provider is certified to provide and the counties the provider is certified to operate within. I understand the persons indicated above as CEO/Responsible Officer and I/DD Waiver Contact will receive Kepro correspondence via the email addresses provided. I understand I am responsible for the provider's Web User maintenance (communicating up-to-date location and service information) and web interface with Kepro.

**CEO/Responsible Officer
Signature*** _____

Date* _____

**CEO/Responsible Officer
Signature** _____

Date _____

Send completed and signed form to your assigned KEPRO Provider Educator.